

Case Number:	CM14-0188951		
Date Assigned:	11/19/2014	Date of Injury:	07/31/2000
Decision Date:	01/08/2015	UR Denial Date:	10/15/2014
Priority:	Standard	Application Received:	11/12/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in General Preventive Medicine and is licensed to practice in Indiana. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This employee is a 57 year old female with date of injury of 7/31/2000. A review of the medical records indicate that the patient is undergoing treatment for intervertebral disc disease of the cervical and lumbar spines with radiculopathy and right shoulder pain. Subjective complaints include continued low back pain with radiation down the right leg, but no numbness or tingling; sharp, pulling, aching right should pain; neck stiffness. Objective findings include limited range of motion of the cervical and lumbar spines with tenderness to palpation of the paravertebrals; positive straight leg raise on the right; limited range of motion of the right shoulder; sensory and neuro exam normal in the upper extremities. Treatment has included Nucynta, Lyrica, Flector patch, Celebrex, and previous radiofrequency ablations at L3-S1. The utilization review dated 1/23/2014 non-certified right radiofrequency ablation of L3-L5 and right shoulder MRI.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Right radiofrequency catheter ablation at 3, 4, 5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint intra-articular injections

(therapeutic blocks); Up to Date, Subacute and chronic low back pain: Nonsurgical interventional treatment

Decision rationale: MTUS is silent regarding medial branch therapeutic blocks. ODG recommends "Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy." ACOEM "does not recommend Diagnostic Blocks". Similarly, Up to Date states "Facet joint injection and medial branch block -- Glucocorticoid injections into the facet joint have not been shown to be effective in the treatment of low back pain. A 2009 American Pain Society guideline recommends against their use". There were several previous diagnostic and therapeutic blocks done with no documentation of the percentage reduction in pain and the duration or any other functional benefit. As such, the request for right L3, L4 and L5 lumbar radiofrequency block is not medically necessary at this time.

Right shoulder MRI: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, MRI

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI)

Decision rationale: ACOEM states 'Primary criteria for ordering imaging studies are:- Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems)- Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon)- Failure to progress in a strengthening program intended to avoid surgery.- Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment)" ODG states "Indications for imaging Magnetic resonance imaging (MRI):- Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs- Subacute shoulder pain, suspect instability/labral tear- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)". The treating physician documented a trial of conservative treatment in a patient older than 40 and her most recent physical exam did not note any of the red flags listed above. Therefore, the request for MRI of the right shoulder is not medically necessary.

