

Case Number:	CM15-0000091		
Date Assigned:	01/09/2015	Date of Injury:	10/16/2000
Decision Date:	03/17/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	12/31/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative Medicine

CLINICAL CASE SUMMARY

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

The injured worker is a 69 year old female, who sustained a work injury on October 16, 2000, resulting in lower back pain. She was a correctional officer for [REDACTED]. Her diagnoses were lumbar joint arthropathy, left sacroiliac joint pain, cervical joint pain, arthropathy and thoracic sacral fusion. Treatments included physical therapy, Non-Steroidal Anti-Inflammatory Drugs, pain medication, 5 lumbar surgeries, and sacroiliac joint injections. Currently, the injured worker complains of difficulty walking, pain in her hip and knee and pain radiating into her buttocks. She states performing activities of daily living (has become difficult. She complains of depression and low self esteem. Present diagnoses are failed back syndrome, postoperative multiple surgical procedures, generalized osteoarthritis with stigmata of rheumatoid arthritis and overuse syndrome of the upper torso and upper extremities bilaterally. On April 25, 2014, Utilization review non-certified fluoroscopically guided sacroiliac joint radio frequency nerve ablation, noting the Official Disability Guidelines (ODG).

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4-L5, fluoroscopically guided facet joint radiofrequency nerve ablation; quantity one: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet Joint

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Soloman M, et al. Radiofrequency treatment in chronic pain. Expert Rev Neurother. 2010; 10(3): 469-474. Medscape, accessed 03/13/2015. http://www.medscape.com/viewarticle/718292_3

Decision rationale: The ACOEM Guidelines in general support the use of radiofrequency ablation for the temporary relief of pain in the upper back. There is limited literature to support this treatment. However, studies have shown mixed results from this treatment for the lower back, and the Guidelines in general do not support it in that setting, especially without investigational dorsal ramus medial branch diagnostic blocks performed first. The submitted and reviewed documentation concluded the worker was suffering from bilateral upper cervical facet joint arthropathy, cervical strain/sprain, left sacroiliac joint pain, post-lumbar laminectomy syndrome, lumbar facet joint arthropathy, and neuropathic pain. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for a fluoroscopically-guided left L4 facet joint radiofrequency nerve ablation is not medically necessary.

Left L5-S1, fluoroscopically guided facet joint radiofrequency nerve ablation; quantity one: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet Joint

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Soloman M, et al. Radiofrequency treatment in chronic pain. Expert Rev Neurother. 2010; 10(3): 469-474. Medscape, accessed 03/13/2015. http://www.medscape.com/viewarticle/718292_3

Decision rationale: The ACOEM Guidelines in general support the use of radiofrequency ablation for the temporary relief of pain in the upper back. There is limited literature to support this treatment. However, studies have shown mixed results from this treatment for the lower back, and the Guidelines in general do not support it in that setting, especially without investigational dorsal ramus medial branch diagnostic blocks performed first. The submitted and reviewed documentation concluded the worker was suffering from bilateral upper cervical facet joint arthropathy, cervical strain/sprain, left sacroiliac joint pain, post-lumbar laminectomy syndrome, lumbar facet joint arthropathy, and neuropathic pain. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for a fluoroscopically-guided left L5 facet joint radiofrequency nerve ablation is not medically necessary.

