

Case Number:	CM15-0003153		
Date Assigned:	01/14/2015	Date of Injury:	07/14/1998
Decision Date:	04/23/2015	UR Denial Date:	12/15/2014
Priority:	Standard	Application Received:	01/07/2015

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: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented 54-year-old who has filed a claim for chronic low back pain (LBP) and complex regional pain syndrome (CRPS) reportedly associated with an industrial injury of July 14, 1998. In a Utilization Review Report dated September 23, 2014, the claims administrator failed to approve a request for multilevel lumbar radiofrequency ablation procedures. EMG testing of the bilateral lower extremities was also denied. The claims administrator, somewhat incongruously, referenced Chapter 8 ACOEM Guidelines of the neck and upper back in the decision to deny electromyography of the lower extremities. Non-MTUS ODG Guidelines were invoked to deny the radiofrequency ablation procedures. A September 10, 2014 progress note was referenced in the determination. The applicant's attorney subsequently appealed. The majority of the information on file, it was incidentally noted, comprised of historical Utilization Review Reports. On December 3, 2014, the applicant reported ongoing complaints of low back pain, reportedly worsening. The attending provider acknowledged that the applicant had received multiple previous lumbar radiofrequency ablation procedures. The applicant reported heightened low back and left leg pain, it was noted in another section of the note. 4+ to 5- to 5/5 lower extremity strength was appreciated. Hyposensorium was noted about the L5-S1 distribution bilaterally. Repeat lumbar radiofrequency ablation procedures were endorsed. Topamax, Effexor, and Motrin were continued. The applicant was given trigger point injections in the clinic. Permanent work restrictions were renewed. A toradol injection was also administered. One of the stated diagnoses was lumbar radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L2-5 Medial Branch Radiofrequency Ablation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: No, the request for a left L2-L5 medial branch radiofrequency ablation procedure was not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 12, page 301 does acknowledge that facet neurotomies should be performed only after appropriate investigation involving diagnostic medial branch blocks, in this case, however, the applicant has already had multiple previous radiofrequency ablation procedures. The applicant has not, however, exhibited a favorable response to the same. The applicant seemingly remains off of work. Permanent work restrictions were renewed, seemingly unchanged, from visit to visit, including on December 3, 2014. The applicant remained dependent on a variety of analgesic and adjuvant medications, including Topamax, Effexor, Motrin, etc., as well as multiple forms of injection therapy, including trigger point injection therapy and intramuscular Toradol injections including on December 3, 2014. All of the foregoing, taken together, suggests a lack of functional improvement as defined in MTUS 9792.20f, despite receipt of multiple prior lumbar radiofrequency ablation procedures. Therefore, the request was not medically necessary.

Right L2-5 Medial Branch Radiofrequency Ablation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: Similarly, the request for right-sided L2-L5 lumbar radiofrequency ablation procedure was likewise not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 12, page 301 does acknowledge that facet neurotomies (AKA radiofrequency ablation procedure) should only be performed after appropriate investigation involving differential dorsal ramus diagnostic medial branch blocks, in this case, however, the applicant has already had multiple prior lumbar radiofrequency ablation procedures but has, however, failed to effect a favorable response to the same. The applicant seemingly remained off of work as of December 3, 2014. Permanent work restrictions were renewed, seemingly unchanged, from visit to visit. The applicant remained dependent on Effexor, Topamax, Motrin, etc. All of the foregoing, taken together, suggested a lack of functional improvement as defined in MTUS 9792.20f, despite receipt of prior lumbar radiofrequency

ablation procedure. Therefore, the request for a repeat radiofrequency ablation procedure was not medically necessary.

EMG Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: Finally, the request for EMG testing of the bilateral lower extremities was likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309, EMG testing is "not recommended" in applicants who carry a diagnosis of clinically obvious radiculopathy. Here, the applicant did, in fact, carry a diagnosis of clinically obvious radiculopathy. The applicant had undergone an earlier lumbar disk replacement procedure. It is not clearly stated how EMG testing would influence or alter the treatment plan. It was not clearly stated why EMG testing was proposed if the diagnosis of lumbar radiculopathy was already clinically evident. Therefore, the request was not medically necessary.