

Case Number:	CM15-0103100		
Date Assigned:	06/05/2015	Date of Injury:	12/11/2002
Decision Date:	07/13/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/29/2015

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, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

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 58 year old female, who sustained an industrial injury on 12/11/2002. Diagnoses have included lumbar facet syndrome, lumbar/thoracic radiculopathy, lumbar facet spondylosis and myofascial pain syndrome. There are associated diagnoses of insomnia. Treatment to date has included physical therapy, acupuncture, chiropractic treatment and medications. The 2010 MRI of the lumbar spine showed multilevel spinal stenosis, spondylosis and facet arthropathy. According to the progress report dated 9/8/2014, the injured worker complained of low back pain. The pain radiated to the buttocks, left leg and right leg. She rated her worst pain as 8/10 and average pain as 5/10. She reported weakness due to pain. The injured worker had tried physical therapy with no relief. The injured worker reported 95% improvement from a transforaminal block of L5 with significant functional improvement. Exam of the lumbar spine revealed tenderness to palpation. Palpation of the lumbar facets revealed positive facet loading. Compression of trigger points elicited local tenderness, referred pain and a local twitch response. There was positive right straight leg raising sign. With findings of right L5 radiculopathy. The medications listed are Ativan, Protonix, hydroxyzine and Tylenol with codeine. Authorization was requested for physical therapy times one to the low back, bilateral lumbar facet #2 L3-S1 and medial branch radiofrequency L3-S1 #4.

IMR ISSUES, DECISIONS AND RATIONALES

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

PT x1 to the low back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 22, 46-47, 96-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low and Upper Back.

Decision rationale: The CA MTUS and the ODG guidelines recommend that physical therapy (PT) can be utilized for the treatment of exacerbation of low back pain. The utilization of PT can result in improved range of motion with reduction in pain and medications utilization. The records indicate that the patient reported that there was no beneficial effect following previous PT and chiropractic treatments. The patient reported that only epidural injections and medication management were beneficial. The criteria for PT X1 of the lumbar spine was not met. Therefore the request is not medically necessary.

Bilateral lumbar facet #2 L3-S1: 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), Low Back Chapter, Medial Branch Block.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, Chronic Pain Treatment Guidelines 9792.29.5 Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low and Back.

Decision rationale: The CA MTUS and the ODG guidelines recommend that facet median branch injection and subsequent rhizotomy procedures can be utilized for the treatment of non radicular low back pain when conservative treatments with medications and PT have failed. The records indicate that the patient had subjective, objective and radiological findings consistent with the diagnosis of lumbar radiculopathy and not facet syndrome. There is documentation of excellent pain relief with functional restoration following transforaminal epidural injections. The guidelines did not recommend utilization of facet injections or rhizotomy procedures for the treatment of lumbar radiculopathy. The criteria for the utilization of bilateral L3 to S1 facet injections # 2 was not met. Therefore the request is not medically necessary.

Medial Branch radiofrequency L3-S1 #4: 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), Pain Chapter, Medial Branch Block.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, Chronic Pain Treatment Guidelines 9792.29.5 Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low and Upper Back.

Decision rationale: The CA MTUS and the ODG guidelines recommend that Facet injection and subsequent rhizotomy procedures can be utilized for the treatment of non radicular low back pain when conservative treatments with medications and PT have failed. The records indicate that the patient had subjective, objective and radiological findings consistent with the diagnosis of lumbar radiculopathy and not facet syndrome. There is documentation of excellent pain relief with functional restoration following transforaminal epidural injections. The guidelines did not recommend utilization of facet injections or rhizotomy procedures for the treatment of lumbar radiculopathy. The criteria for the utilization of bilateral L3 to S1 median branch radiofrequency # 4 was not met. Therefore the request is not medically necessary.