

Case Number:	CM15-0109033		
Date Assigned:	06/15/2015	Date of Injury:	07/17/2012
Decision Date:	07/14/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/05/2015

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: New York

Certification(s)/Specialty: Neurological Surgery

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 44 year old female, who sustained an industrial injury on 07/17/2012. Initial complaints and diagnosis was note clearly documented. The injured worker was noted to be injured while working as highway patrol officer. On provider visit dated 05/04/2015 the injured worker has reported low back pain. On examination of the lumbar spine was noted to have a reduced range of motion and mild tenderness noted at left trochanteric bursa, right trochanteric bursa and lumbar facets L4-L5, L5-S1 bilaterally. The diagnoses have included osteoarthritis-general, lumb/lumbosac disc degenerative and spinal stenosis-lumbar. Treatment to date has included medication and physical therapy. Injured worker underwent a laminectomy in 12/2013. The provider requested TENS unit indefinite use, follow right and left L4-L5 radiofrequency ablation and follow right and left L5-S1 radiofrequency ablation.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit, indefinite use: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain Page(s): 114-5.

Decision rationale: The California MTUS guidelines do not recommend TENS as a primary treatment modality. They do recommend a one month home-based trial may be considered for neuropathic pain such as CRPS II, diabetic neuropathy, post-herpetic neuralgia, phantom limb, spasticity and multiple sclerosis. Documentation does not state the patient has any of these entities. The request for treatment does not follow these recommendations. The requested treatment: TENS Unit, indefinite use is NOT Medically necessary and appropriate.

Follow Right L4-L5 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, Criteria for use of facet joint radiofrequency neurotomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide such evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: Follow Right L4-L5 Radiofrequency Ablation is not Medically necessary and appropriate.

Follow Left L4-L5 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, Criteria for use of facet joint radiofrequency neurotomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-07.

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide such evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: Follow left L4-L5 Radiofrequency Ablation is not Medically necessary and appropriate.

Follow Right L5-S1 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, Criteria for use of facet joint radiofrequency neurotomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-07.

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide such evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: Follow Right L5-S1 Radiofrequency Ablation is not Medically necessary and appropriate.

Follow Left L5-S1 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, Criteria for use of facet joint radiofrequency neurotomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-07.

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide such evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: Follow left L5-S1 Radiofrequency Ablation is not Medically necessary and appropriate.