

Case Number:	CM15-0028140		
Date Assigned:	03/25/2015	Date of Injury:	06/16/2010
Decision Date:	05/01/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	02/13/2015

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 (IW) is a 51-year-old male who sustained an industrial injury on 06/16/2010. The original injury involved the neck and mid back, right knee, left hip, left shoulder and psyche. Diagnoses include lumbosacral spondylosis, pain in joint lower leg, s/p arthroscopy right knee x two, pain-psychogenic NEC and long-term use meds, NEC. Treatment to date has included medications, functional restoration program, acupuncture, physical therapy, aqua therapy, TENS unit and radiofrequency nerve ablations (RFA). Diagnostics performed to date included x-rays, MRIs and psychological testing. According to the progress notes dated 2/3/15, the IW reported severe knee and back pain. The requested treatment, radiofrequency nerve ablations under fluoroscopy with IV sedation, was included in the provider's treatment plan for the IW's severe back pain due to previous success with RFAs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency ablation at bilateral L4: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back-lumbar and thoracic Chapter (updated 04/15/15)-facet joint radiofrequency neurotomy.

Decision rationale: The ODG guidelines note that facet joint radiofrequency neurotomy is under study. It is also known as radiofrequency ablation (RFA). The guidelines note that RFA is not supported by convincing, consistent evidence of benefit. They recommend in the criteria for use that there should be a formal plan of additional evidence-based conservative care in addition to the facet joint therapy. Documentation is not provided which describes such a plan. Documentation is not provided which describes those factors associated with failed treatment or the factors associated with success in addition the statement about benefit from the prior RFAs. Documentation of how benefit was objectively measured is not provided. The requested treatment: Radiofrequency ablation at bilateral L4 is not medically necessary and appropriate.

Radiofrequency ablation at bilateral L5: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Radiofrequency ablation at bilateral L4 is not medically necessary and appropriate, then the Requested Treatment: Radiofrequency ablation at bilateral L5 is NOT Medically necessary and appropriate.

Decision rationale: Since the requested treatment: Radiofrequency ablation at bilateral L4 is not medically necessary and appropriate, then the Requested Treatment: Radiofrequency ablation at bilateral L5 is NOT Medically necessary and appropriate.

Fluoroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Radiofrequency ablation at bilateral L4 is not medically necessary and appropriate, then the Requested Treatment: fluoroscopy is NOT Medically necessary and appropriate.

Decision rationale: Since the requested treatment: Radiofrequency ablation at bilateral L4 is not medically necessary and appropriate, then the Requested Treatment: fluoroscopy is NOT Medically necessary and appropriate.

IV sedation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Radiofrequency ablation at bilateral L4 is not medically necessary and appropriate, then the Requested Treatment: iv sedation is NOT Medically necessary and appropriate.

Decision rationale: Since the requested treatment: Radiofrequency ablation at bilateral L4 is not medically necessary and appropriate, then the Requested Treatment: iv sedation is NOT Medically necessary and appropriate.