

Case Number:	CM15-0094883		
Date Assigned:	05/21/2015	Date of Injury:	07/28/2014
Decision Date:	06/25/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/15/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic 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 64-year-old male who sustained an industrial injury on 7/28/14. Injury was reported due to a continuous trauma type injury while working as a custodian. The 1/7/15 bilateral hand x-rays demonstrated arthritic changes with joint space narrowing and osteophyte formation at the carpometacarpal joint. The 1/17/15 lumbar spine x-rays demonstrated disc space narrowing at L5/S1. Records indicated that the patient had completed 14/14 visits of physical therapy for the lumbar spine as of 12/18/14 with an additional 12 visits of physical therapy requested on 1/7/15. Records indicated that a home exercise program was recommended on 3/11/15. The 4/13/15 treating physician report cited low back pain radiating down the left lower extremity. Physical exam documented left lower lumbar spasms and point tenderness, and positive left Lasegue's test. There was mild loss of lumbar range of motion and pain with motion. Bilateral hand exam documented no swelling or deformity. There was crepitus and pain about the carpometacarpal (CMC) joints of both thumbs. Upper extremity neurologic exam was within normal limits. Lower extremity neurologic exam documented decreased sensation over the lateral aspect of the left foot. The diagnosis was bilateral hand/thumb arthritis at the CMC joint and lumbar disc bulge at L5/S1 with left sided S1 radiculopathy. The treatment plan requested authorization for pain management to perform ablation for the lumbar spine, lumbar spine MRI, physical therapy 3x4 for the lumbar spine, and medications to include Flexeril, Celebrex, and Ultram. The injured worker was off work. The 4/24/15 utilization review modified the 4/13/15 request for consult and treatment, possible ablation therapy with a pain management specialist to a pain management consult, with treatment authorization withheld until the orthopedic consultation had been completed and recommendations evaluated. The request for physical therapy three times weekly per the 4/13/15 order was non-certified as there was no documentation in the medical records whether the injured worker had received the physical therapy previously requested on 1/7/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Possible ablation therapy, lumbar spine, per 04/13/15 order: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic, Facet joint diagnostic blocks (injections); Facet joint radiofrequency neurotomy.

Decision rationale: The California MTUS guidelines state that facet neurotomies are under study and should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The Official Disability Guidelines indicate that facet joint radiofrequency ablation (neurotomy, rhizotomy) is under study. Treatment requires a diagnosis of facet joint pain using one set of diagnostic medial branch blocks with a response of 70%. The pain response should last at least 2 hours for Lidocaine. There should be evidence of a formal plan of additional evidenced based conservative care in addition to facet joint therapy. The ODG do not recommended facet joint diagnostic blocks for patients with radicular low back pain. Guideline criteria have not been met. This patient presents with radicular low back pain and a diagnosis of lumbar disc bulge with S1 radiculopathy. There is no evidence of a lumbar diagnostic medial branch block with guideline recommended response. The 4/24/15 utilization review modified this request to a pain management consult. Given the failure to meet guideline criteria for ablation, additional certification is not supported. Therefore, this request is not medically necessary.

Associated surgical service: physical therapy, 3 times weekly, lumbar spine, per 04/13/15 order Qty: 12: 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 Introduction; Physical Medicine Page(s): 9, 98-99.

Decision rationale: The California MTUS guidelines recommend that all therapies be focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. In general, the MTUS guidelines would support up to 10 visits for myalgia, myositis, neuralgia, neuritis, and radiculitis. Guideline criteria have not been met. There is no current documentation of a specific functional deficit or functional treatment plan to be address with additional supervised physical therapy. The patient has been provided a home exercise program. There is no compelling reason to support the medical necessity of additional supervised physical therapy over an independent home exercise program at this time. Therefore, this request is not medically necessary.