

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/11/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/8/2013
Date of Injury:	1/21/2009
IMR Application Received:	8/15/2013
MAXIMUS Case Number:	CM13-0011642

- 1) MAXIMUS Federal Services, Inc. has determined the request for one (1) **bilateral permanent lumbar facet injection aka radiofrequency ablation, fluoroscopic guidance, IV sedation is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/15/2013 disputing the Utilization Review Denial dated 8/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/23/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for one (1) **bilateral permanent lumbar facet injection aka radiofrequency ablation, fluoroscopic guidance, IV sedation is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The patient is a 35-year-old male who reported a work-related injury on 01/21/2009 as result of an initial injury to the right knee. The clinical note dated 09/03/2013 reports appeal document by the patient's primary treating provider for the current diagnosis, low back pain, under the care of [REDACTED]. The provider documents the patient underwent MRI of the lumbar spine on 05/04/2010 which revealed transitional vertebrae in the lumbosacral junction, straightening of the lumbar lordosis, a mild focal disc protrusion at L5-S1, and some foraminal narrowing. The patient continues to present with complaints of low back pain. The patient has undergone extensive conservative management including physical therapy, massage therapy, medication management, and home exercises with failure of all interventions. The patient underwent a right lumbar radiofrequency ablation on 06/04/2013 and received 85% relief of his pain complaints. The patient also underwent a left diagnostic lumbar facet injection on 07/30/2013 with significant improvement in his pain. The provider documented the patient obtained about 60% relief of his pain following the procedure and was able to bend and twist at the waist with less pain. The patient also reported improvements in mobility. Therefore, the provider requested a permanent left radiofrequency ablation at L3-4 and L4-5. Upon physical exam of the patient, lumbar flexion was measured to be 70 degrees, left lateral bending was measured to be 15 degrees, and right lateral bending was measured to be 25 degrees. Tenderness to palpation was noted over the left lumbar facet joints, particularly at L3-5. The patient also had pain elicited with lumbar facet loading; extension and rotation on the left only. The provider documented the patient no longer has pain with facet loading to the right. The patient does have left-sided low back pain with extension on the left side, but no longer on the right. The provider documented modification of the request to a left lumbar radiofrequency ablation at L3-4 and L4-5. The clinical notes document the patient utilizes naproxen, morphine, and Robaxin for

his pain complaints. The patient has physical exam findings of axial loading pain and tenderness to palpation noted over the left lumbar facet joints, particularly at L3-5.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records from:
 - ☒ Claims Administrator
 - ☒ Employee/Employee Representative
 - ☒ Provider

1) Regarding the request for one (1) bilateral permanent lumbar facet injection aka radiofrequency ablation, fluoroscopic guidance, IV sedation:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 12 (Low Back Complaints) (2004), page 300-301.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 301, which is part of the MTUS. The Expert Reviewer also cited the Official Disability Guidelines (ODG) Low back chapter, which is not part of the MTUS.

Rationale for the Decision:

The MTUS/ACOEM Guidelines indicate that quality literature does not exist regarding radiofrequency neurotomy of facet joint nerves in the lumbar region. The Official Disability Guidelines recommend additional evidence-based conservative care in addition to facet joint therapy. The medical records provided for review indicate that the employee has reported positive efficacy with a previous right lumbar radiofrequency ablation, resolving 85% of the employee's pain. The medical records do not show evidence of a course of treatment with support of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. **The request for one (1) bilateral permanent lumbar facet injection aka radiofrequency ablation, fluoroscopic guidance, IV sedation is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.