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**Notice of Independent Medical Review Determination**

Dated: 10/3/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]  
7/8/2013

12/20/1999

7/19/2013

CM13-0002110

- 1) MAXIMUS Federal Services, Inc. has determined the request for radiofrequency bilateral lumbar facet at L4-L5, L5-S1 under fluoroscopy **is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/19/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/24/2013. 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 radiofrequency bilateral lumbar facet at L4-L5, L5-S1 under fluoroscopy **is 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 Anesthesiology, and 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.

### **Case Summary:**

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 8, 2013:

“Clinical summary: According to the Interim Progress Report dated 06/24/13 by Dr. [REDACTED], the 39-year-old patient complained of severe low back pain, bilateral buttocks and bilateral groin pain. Pain level was 8/10. Pain was sharp, shooting, stabbing and burning in nature in the low back down to both hips and both groins. The patient denied having any pain going into the lower extremities. On examination, lumbar spine was tender from L3 to L5 level bilaterally. There was bilateral lumbar facet tenderness at L3-L4, L4-L5, and L5-S1 level. Pain in the lumbar spine worsened on extension, side bending and rotation of the spine. Range of motion of the lumbar spine was limited. Neurologic examination was normal. There was no evidence of lumbar radiculopathy. The patient was diagnosed with lumbar spondylosis without myelopathy; bilateral lumbar facet syndrome; mechanical low back pain; status post diagnostic lumbar facet injection with positive results; failed conservative therapies for pain control (physical therapy modalities, chiropractic treatment, anti-inflammatory medications and muscle relaxants) for more than twelve weeks.”

### **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 for Independent Medical Review (received 7/19/2013)
- Utilization Review Determination from [REDACTED] (dated 7/8/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

**1) Regarding the request for radiofrequency bilateral lumbar facet at L4-L5, L5-S1 under fluoroscopy:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Low Back Chapter, pages 298-301, which are part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Low Back Chapter, Facet Joint Radiofrequency Neurotomy section, which is a medical treatment guideline that is not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer determined that the MTUS does not list criteria for the requested treatment. The Expert Reviewer found the ODG section used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 12/20/1999 and has experienced intractable low back pain and bilateral hip pain (right worse than left), and right leg pain. Diagnoses include lumbar spondylosis without myelopathy, right lumbar radiculopathy with neuroclaudication, and degenerative disc disease lumbar spine. Treatment has included physical therapy, anti-inflammatory medications, muscle relaxants, chiropractic treatments, and epidural injections. A request was submitted for bilateral lumbar facet at L4-L5, L5-S1 under fluoroscopy.

The ODG indicates that criteria for facet joint radiofrequency neurotomy require a diagnosis of facet joint pain using a medial branch block. Per the ODG, a neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50 percent relief. The submitted medical records document evidence of adequate diagnostic blocks performed on 6/21/2013, and there is evidence of a 50 percent improvement for almost 5 months after previous treatment in this case. The requested bilateral lumbar facet at L4-L5, L5-S1 under fluoroscopy **is 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;

Richard C. Weiss, MD, MPH, MMM, PMP  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
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/srb

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.