

<b>Case Number:</b>	CM13-0001802		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	08/08/2002
<b>Decision Date:</b>	01/14/2014	<b>UR Denial Date:</b>	07/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Ohio and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 60-year-old male who reported an injury on 08/02/2002. The patient underwent a radiofrequency in May of 2011. It was documented that the patient's pain was well-controlled at 75% for approximately 20 months. The decrease in pain levels allowed the patient to participate in a home exercise program and perform activities of daily living. In combination with the radiofrequency ablation, the patient was treated with medications and sacroiliac joint injections. The most recent clinical evaluation findings include pain complaints rated at a 6/10. Range of motion was significantly limited due to exquisite pain, with normal sensation and normal motor function. The patient's diagnoses included left lumbar facet pain involving L4-5 and L5-S1, left-sided thoracic outlet syndrome, and repetitive stress injury. The patient's treatment plan included repeat radiofrequency ablation and a Qualified Medical Evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left side lumbar radiofrequency to treat L4-5 and L5-S1:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

**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 Chapter.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested left-sided lumbar radiofrequency to treat the L4-5 and L5-S1 is medically necessary and appropriate. The clinical documentation submitted for review does provide evidence that the patient received a radiofrequency ablation at the L4-5 and L5-S1 level in 05/2011. The clinical documentation submitted for review does support that the patient was able to participate in a home exercise program and activities of daily living as a result of this procedure. Pain control was described as 75% for approximately 20 months. Official Disability Guidelines state, "while repeat neurotomies may be required, they should not be required at an interval of less than 6 months from the first procedure. Duration of effect after the first neurotomy should be documented for at least 12 weeks at greater than 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months' duration.)" The clinical documentation submitted for review does provide evidence that the previous radiofrequency ablation provided 75% sustained pain relief. As this allowed for the patient to participate in a home exercise program and perform activities of daily living, an additional radiofrequency neurotomy would be supported. As such, the requested left-sided lumbar radiofrequency to treat L4-5 and L5-S1 is medically necessary and appropriate.