

Case Number:	CM13-0036712		
Date Assigned:	12/13/2013	Date of Injury:	08/03/2009
Decision Date:	03/17/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/21/2013

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 Interventional Spine 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 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 56-year-old male with date of injury on 08/03/2009. The progress report dated 09/06/2013 by [REDACTED] indicates that the patient's diagnoses include lumbar degenerative disk disease, lumbar facet syndrome and lumbar myofascial pain. The patient continues with significant left-sided low back pain. It was noted that he did get significant relief of symptoms after the radiofrequency ablation that he had performed on 03/13/2013. However, some of those symptoms have returned. It has been 6 months since the last series of radiofrequency ablation. The physical exam findings include tenderness along the left-sided lumbar paraspinal muscles and left buttock region, positive facet loading test on the left side and limited range of motion. The patient can reach 4 inches from the ground with his fingertips. Straight leg test is negative. FABERE test is negative. Muscle strength is 5/5 in the upper and lower extremities. A request was made for repeat left L3, L4, and L5 radiofrequency ablation of the medial branch nerves. Six sessions of chiropractic treatment were also requested for range of motion and core stabilization. The utilization review letter dated 10/10/2013 appears to have denied the radiofrequency ablation but had approved the 6 sessions of chiropractic treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left medial branch nerve radiofrequency ablation at L3/L4/L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Other evidence-based documentation

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar Facet Joint Radiofrequency Neurotomy.

Decision rationale: Regarding the medial branch radiofrequency ablation, the medical records appear to indicate this patient does suffer from facetogenic pain. A radiofrequency ablation had been performed 6 months prior in March of 2013. The 05/07/2013 progress report indicated that the patient had received 50% to 60% improvement; however, the duration of that improvement was not indicated. It appears the improvement was being maintained at that point. The California MTUS is silent on radiofrequency ablation. ODG Guidelines were reviewed. The criteria for facet joint radiofrequency neurotomy state that repeat procedure should not be performed unless there is relief from the first procedure documented at least 12 weeks at greater than 50% relief. Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. The progress report dated 06/21/2013 indicates that the patient had a return of radicular symptoms into the left side of the back radiating into the left buttock and left leg. The duration of benefit was not documented. It would appear that given the patient's return of symptoms as early as 6/21/13, the patient does not appear to meet the required 12 week criteria per ODG guidelines. Furthermore, there is no documentation of functional improvement such as return to work, significant improvement in ADL's, AND reduced dependency on medical treatments. Therefore, recommendation is for denial.

Post op chiropractic visits two times a week for three weeks:

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other evidence-based documentation

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Section Page(s): 58.

Decision rationale: Regarding the post op chiropractic treatment 6 sessions, the utilization review letter appears to have modified this to approve 6 sessions of chiropractic treatment. The medical records indicate that the patient has had chiropractic treatment in the past with benefit and was experiencing increased left-sided low back pain and had a reduction of radicular symptoms on the 09/06/2013 progress report. The California MTUS page 58 states that a trial of 6 visits over 2 weeks is recommended for a trial of chiropractic treatment. This request appears to be reasonable and supported by the guidelines noted above and therefore authorization is recommended.