

<b>Case Number:</b>	CM14-0133239		
<b>Date Assigned:</b>	08/22/2014	<b>Date of Injury:</b>	02/24/2008
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation 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 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 records presented for review indicate that this 35 year-old female was reportedly injured on February 24, 2008. The most recent progress note presented for review is dated August 8, 2014, indicates that there are ongoing complaints of low back pain and constipation. Urine drug screening was consistent for the medications being prescribed. A pain management contract is also referenced. The physical examination demonstrated a 5'4", 154 pound individual who is normotensive (126/78). There was tenderness to palpation in the cervical spine along the bilateral facet joints. A decrease in cervical spine range of motion is also noted. Motor function is described as 5/5 and deep tendon reflexes are intact. The lumbar spine examination noted a decrease in range of motion, tenderness to palpation, and manual motor testing was described as 5/5. Diagnostic imaging studies are not referenced in this note. Previous treatment includes lumbar laminectomy (1998) carpal tunnel release, and left shoulder surgery. A request had been made for occipital nerve radiofrequency neurotomy and an epidural steroid injection which was not certified in the pre-authorization process on August 18, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Greater Occipital nerves Radio frequency Neurotomy C5-6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Greater Occipital Therapeutic Nerve Blocks

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence; American College of Occupational and Environmental Medicine (ACOEM), Cervical and Thoracic Spine: Clinical Measures; Injection Therapy, Radiofrequency Neurotomy, (electronically cited).

**Decision rationale:** As outlined in the ACOEM guidelines, there is no recommendation for the use of radiofrequency neurotomy. However, such an intervention is designed to address facet joint pain. Occipital nerve issues are not noted in the progress notes, and there is no complaints of headache. The low back complaints date back to the 1998 surgery and the neck pain to the current injury, however the physical examination reported noted facet joint issues and not findings consistent with occipital nerve issue. Therefore, when noting the clinical data presented (specifically pain control with oral medications), the medical necessity for this intervention cannot be established.

**Interfaminar Epidural Steroid Injections L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46 of 127.

**Decision rationale:** The prior surgical history noted a lumbar laminectomy dating back to 1998. The current physical examination specifically notes complaints of pain, a decrease in lumbar spine range of motion, however, motor function is reported as 5/5, deep tendon reflexes are 2+ and no sensory losses noted. Therefore, there is no clinical indication of a radiculopathy which this injection would be addressing. As noted in the MTUS, there is support for epidural steroid injections when a radiculopathy is documented and corroborated with physical examination and electrodiagnostic studies. Based on the clinical information presented, there is no corroboration noted and as such the medical necessity for this procedure cannot be supported.