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| Case Number: | CM14-0158017 | | |
| Date Assigned: | 10/01/2014 | Date of Injury: | 01/27/2011 |
| Decision Date: | 12/31/2014 | UR Denial Date: | 09/16/2014 |
| Priority: | Standard | Application Received: | 09/26/2014 |

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 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 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 patient is a 51 year old male with an injury date of 01/27/11. Based on the 04/01/14 progress report, the patient complains of left knee pain and chronic low back pain. No exam findings were provided. "He has had cortisone injections twice in both knees with limited improvement." On 11/07/13, he underwent a left total knee replacement arthroplasty and on 08/15/14, he had a left-sided lumbar L3, 4, & 5 medial branch blocks with fluoroscopy. The 12/17/12 x-ray of the lumbar spine revealed the following: 1. Mild to moderate multilevel discogenic degenerative disease from L1 to L5. 2. Bilateral lower lumbar facet arthrosis. The 12/17/12 MRI of the lumbar spine revealed the following: 1. L2-3 minimal foraminal disc protrusion. 2. L3-4 mild left foraminal and far lateral disc protrusion. 3. L4-5 congenital small canal with mild disc bulging and osteophytic ridging creating moderate central spinal canal with moderate bilateral lateral recess stenosis exacerbated by posterior element hypertrophy. The patient's diagnoses include the following: 1. Hypertension. 2. Pneumonia. 3. Esophageal reflux. 4. Peptic ulcer. 5. Arthritis. 6. Sleep apnea. The utilization review determination being challenged is dated 09/16/14. There was one treatment report provided from 04/01/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency ablation facet joint: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back , Facet joint radiofrequency neurotomy

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, Facet joint diagnostic blocks (injections)

Decision rationale: According to the 04/01/14 report, the patient presents with left knee pain and chronic low back pain. The request is for a Radiofrequency Ablation Facet Joint. The report with the request was not provided. ODG guidelines states the following regarding the use of diagnostic blocks for facet "mediated" pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. The 08/15/14 operative report of the diagnostic medial branch block indicates that the patient did not have any immediate relief after the injection. The patient rated his pain as a 6/10 both before and after the injection. The utilization review letter states that on the following day, "the claimant reports pain reduction from 6/10 to 4/10. He notes that his pain has returned and is more severe. He also notes after the procedure he was able to work with less pain and walk for about 15 minutes." The patient's decrease in pain from 6/10 to a 4/10 does not result in 70% relief, as required by ODG guidelines. More importantly, the patient did not experience any pain reduction on the day of the procedure. This is a negative response and the requested RF ablation would not be indicated. Recommendation is not medically necessary and appropriate.