

Case Number:	CM14-0166964		
Date Assigned:	11/18/2014	Date of Injury:	04/01/2012
Decision Date:	01/06/2015	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/09/2014

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 Orthopedic Spine Surgery 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 injured worker is a 59-year-old male who reported an injury on 04/01/2012. The mechanism of injury was reported to have occurred while the injured worker was pulling on ropes. His relevant diagnoses include lumbago and status post bilateral rotator cuff repairs. Past treatments include physical therapy, work modifications, medications, exercise, cortisone injections, acupuncture, and bilateral L3, L4, and L5 medial branch blocks. Pertinent diagnostics include an official magnetic resonance imaging of the lumbar spine performed on 10/11/2012 with findings at the L1-2 disc level; minimal disc bulging with some abnormal slight intensity consistent with mucoid degeneration without significant spinal canal or neural foraminal stenosis. L2-3 disc level: minimal disc bulging with abnormal signal intensity consistent with mucoid degeneration. L3-4 disc level: disc bulging without evidence of impingement on the neural elements. L4-5 disc level: disc bulging without significant spinal canal or neural foraminal stenosis. L5-S1 disc level: left paracentral disc protrusion at the L5-S1 disc level with encroachment on the spinal canal and left lateral recess and abutment on the thecal sac. Associated loss of intervertebral disc space height and abnormal signal intensity consistent with mucoid degeneration. His surgical history included a right rotator cuff repair on 08/06/2012 and a left rotator cuff repair on 08/14/2013. At an examination on 09/22/2014, the injured worker complained of low back pain rated 4/10. Upon physical examination of the lumbar spine, the documentation submitted for review indicated that there were no changes from the previous visit on 09/03/2014 which noted that the patient's range of motion was restricted with extension limited to 20 degrees, lateral rotation to the left was limited to 30 degrees due to pain, and lateral rotation to the right was limited to 30 degrees due to pain but normal flexion. Lumbar facet loading was positive on both sides. Straight leg raise test was negative. All lower extremity reflexes were equal and symmetric. The injured worker's current medication regimen was noted to include

Cyclobenzaprine 7.5 mg tablets 1 taken 3 times a day as needed for spasm, Omeprazole DR 20 mg twice a day, Voltaren XR 100 mg 1 daily, Finasteride 1 mg, Flomax 0.4 mg, Ibuprofen 200 mg every day as needed for pain, and Lipitor 40 mg. The treatment plan included an appeal for the right then left L4 and L5 radiofrequency to an independent pay doctor. A request was received for right then left L4 to L5 radiofrequency ablation to be done on separate days. The Request for Authorization form was provided in the submitted documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right then left L4-L5 radiofrequency ablations to be done on separate days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar and Thoracic

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet joint diagnostic blocks (injections), and Facet joint radiofrequency neurotomy.

Decision rationale: The request for Right then left L4-L5 radiofrequency ablations to be done on separate days is not medically necessary. Documentation submitted for review indicated the injured worker had low back pain rated 4/10 at his most recent assessment. CAMTUS/ACOEM states that there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. The Official Disability Guidelines recommended criteria for use of facet joint radiofrequency neurotomy treatment requires a diagnosis of facet joint pain using the medial branch block with a response of greater than 70% pain relief. Additionally, the recommended criteria include documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDs prior to the procedure for at least 4 to 6 weeks. There was no documented pain relief using a Visual Analog Scale following the bilateral L3, L4, and L5 medial branch blocks. As such, the request for Right then left L4-L5 radiofrequency ablations to be done on separate days is not medically necessary.