

Case Number:	CM15-0149031		
Date Assigned:	08/12/2015	Date of Injury:	03/21/1986
Decision Date:	09/15/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	07/31/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 61 year old male, who sustained an industrial injury on 3-21-86 Initial complaints were of his neck and back. The injured worker was diagnosed as having chronic pain syndrome; lumbar disc displacement with radiculitis; lumbosacral spondylosis without myelopathy; dietary surveillance and counseling; overweight; lumbar and cervical postlaminectomy syndrome; cervicgia; cervical spondylosis without myelopathy. Treatment to date has included status post anterior cervical disc fusion C4-C5, C5-C6 and C6-C7 (2004); status post lumbar fusion (3-2012). Medial Branch Block left C2, C3, C4, (5-19-14); Left radio frequency lesioning C2, C2-C3, C3 and C4 (7-2014); physical therapy; urine drug screening; medications. Currently, the PR-2 notes dated 6-3-15 indicated the injured worker presented to this office for a follow-up evaluation and management of his chronic pain. He complains of low back pain right worse than the left and neck pain and stiffness improved with radiofrequency. The radiofrequency lesioning gave him 70-80% improvement for at least 8 months. He is having significant low back pain requiring medications and came in for an evaluation. He is complaining of bilateral lower back pain and the pain radiates around especially the right side of the lower back accompanied by pain running into the right buttocks and intermittent pain that goes down the right leg as well as complaints of mid-back pain. He has been using Percocet 4 tablets per day and reports this overall helps to decrease the pain by 50%. He is also using Ambien for sleep and continues to use Naprosyn twice a day. He reports he is still using Doxepin however unsure what it for and twice a day. He is not working and reports the pain interferes with his activities of daily living. His worst pain is rated at 10 out of 10 and averages 6 out of 10.

He has brought his pain medicine in for a count. He has also has transforaminal epidural steroid injections in the past with a negative response. A lumbar discogram L3-4, L4-5 and L5-S1 was done on 10-1-10 showing an annular tear at L4-5 L5-S1 with Concordant pain, L3-4 showed a tear on post discogram CT but was asymptomatic. A MRI of the lumbar spine done on 4-12-11 indicated worsening disc degeneration at L3-4 with narrowing of disc space and moderately severe left foraminal stenosis due to disc protrusion and facet joint hypertrophy. This degeneration is noted at L4-5 and L5-S1 level with facet joint hypertrophy contributing to moderate bilateral foraminal stenosis and loss of disc height. On physical examination, the provider documents cervical range of motion restricted and painful at extremes and most difficult for him to turn his head to the left. Previous ACDF scar is noted and Spurling's sign is negative. He has sub-occipital-occipital tenderness. Scars of previous lumbar surgery are noted with facet tenderness and painful lower back. Spine extension is restricted and painful bilaterally He can flex forward touch to below his knees. The provider is requesting authorization of radiofrequency lesioning of medical branches at left C4, C3, C2-C3, C2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency lesioning of medical branches at left C4, C3, C2-C3, C2: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back (Acute & Chronic) Chapter, under Facet joint radiofrequency neurotomy.

Decision rationale: The patient presents with low back and neck pain. The request is for Radiofrequency Lesioning of medical branches at left C4, C3, C2-3, C2. The request for authorization is not provided. The patient is status post three level fusion C4-C7, 2004. X-ray of the cervical, 04/01/14, shows instrumentation at C4-C7, reversal of cervical lordosis at C3-C4, positive facet arthritis, narrowing of neural foramina, hardware intact with flexion extension. He underwent LEFT-sided radiofrequency lesioning on 07/28/14, which has given him 70-80 percent improvement for at least 8 months. Physical examination of the neck reveals scar of previous ACDF noted. Range of motion restricted and painful at extremes, it is most difficult to turn his head to the LEFT. Patient's past treatments include medications, injections, physical therapy, surgery, activity modification and cervical radiofrequency lesioning. Patient is recommended a regular exercise program. Patient's medications include Percocet, Ambien, Naprosyn, Doxepin, Prilosec, Aspirin, Perdiem, Simvastatin and Lisinopril. Per progress report dated 06/03/15, the patient is not working and P&S. ODG-TWC Guidelines, Neck and Upper back (Acute & Chronic) Chapter, under Facet joint radiofrequency neurotomy Section states: "Criteria for use of cervical facet radiofrequency neurotomy: 1. Treatment requires a diagnosis of facet joint pain. See Facet joint diagnostic blocks. 2. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function. 3. No more than two joint levels are to be performed at one time (See Facet joint diagnostic blocks). 4. If different regions require neural blockade, these should be performed at intervals of not sooner than one week, and preferably 2 weeks for most blocks. 5. There should be evidence of a formal plan of rehabilitation in addition to facet joint therapy. 6. 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 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. Per progress report dated 06/03/15, treater's reason for the request is "He reports also having neck pain, accompanied with neck stiffness." The patient presents with non-radicular neck pain and has failed to respond to conservative treatments. In this case, the patient is status post diagnostic medial branch block left C2, C3, C2-C3, C4 on 05/19/14, and status post LEFT-sided radiofrequency lesioning on 07/28/14. Treater states, "70-80 percent improvement for at least 8 months". Given the documentation of efficacy of the prior radiofrequency lesioning, as required by the ODG, the request appears reasonable and within guidelines indication. Therefore, the request is medically necessary.