

<b>Case Number:</b>	CM15-0221934		
<b>Date Assigned:</b>	11/17/2015	<b>Date of Injury:</b>	04/19/1996
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	10/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2015

### 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:

This injured worker is a 57 year old male, who sustained an industrial injury on 04-19-1996. The injured worker was diagnosed as having lumbar spondylosis without myelopathy, lumbar herniated disc, lumbar degenerative disc disease, lumbago and bilateral sacroiliitis. On medical records dated 09-09-2015, the subjective complaints were noted as bilateral back pain. Pain was rated 8 of out 10 as average and 9 out of 10 at its worst. Objective findings were noted a tenderness to palpation along bilateral mid to lower lumbar paraspinal muscles and along bilateral sacroiliac joints, and positive lumbar facet loading test bilaterally. Treatments to date included medication, acupuncture, physical therapy, epidural injections and rhizotomy bilaterally. Current medications were listed as Atenolol and Coumadin. The Utilization Review (UR) was dated 10-14-2015. A Request for Authorization was dated 09-09-2015. The UR submitted for this medical review indicated that the request for 12 chiropractic treatments was non-certified and 1 radiofrequency ablation of medial branching innervation right sided L3-4, L4-5 and L5-S1 was modified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 radiofrequency ablation of medial branches innervating right sided L3-4, L4-5 and L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back, Lumbar & Thoracic (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) Low Back Chapter, under Facet joint radiofrequency neurotomy.

**Decision rationale:** The current request is for 1 radiofrequency ablation of medial branches innervating right sided L3-4, L4-5 and L5-S1. Treatment to date included left shoulder subacromial decompression in 2014, chiropractic treatments, medication, acupuncture, physical therapy, epidural injections and rhizotomy bilaterally. Work status was not provided. Official Disability Guidelines, Low Back Chapter, under Facet joint radiofrequency neurotomy has the following: Under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis (only 3 RCTs with one suggesting pain benefit without functional gains, potential benefit if used to reduce narcotics). Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints. Criteria for use of facet joint radiofrequency neurotomy: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections). (2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is 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. (3) 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. (4) No more than two joint levels are to be performed at one time. (5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. (6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. Per report 09/09/15, the patient presents with lower back pain. Examination revealed tenderness to palpation along bilateral mid to lower lumbar paraspinal muscles and along bilateral sacroiliac joints and positive lumbar facet loading test bilaterally. The treater reported that the patient underwent a radiofrequency ablation in August 2010 and 2011 which provided significant decrease in pain for 6-7 months. The patient reported improved function, which allowed him to discontinue medications. In this case, although functional improvement was documented with the prior neurotomy, the current request is for "radiofrequency ablation of medial branching innervation right sided L3-4, L4-5 and L5-S1." ODG states that "(4) No more than two joint levels are to be performed at one time." Therefore, the request is not medically necessary.

**12 Chiropractic treatments:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The current request is for 12 chiropractic treatments. Treatment to date included left shoulder subacromial decompression in 2014, chiropractic treatments, medication, acupuncture, physical therapy, epidural injections and rhizotomy bilaterally. Work status was not provided. MTUS guidelines, Manual therapy and Manipulation section, pages 58-59, recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. Per report 09/09/15, the patient presents with lower back pain. Examination revealed tenderness to palpation along bilateral mid to lower lumbar paraspinal muscles and along bilateral sacroiliac joints and positive lumbar facet loading test bilaterally. The treater recommended chiropractic therapy 2 times a week for 6 weeks for evaluation and treatment of the lower back. This patient has had prior chiropractic treatments for his shoulder complaints; however, there is no indication of prior chiropractic treatment for the lumbar spine. Given the patient's diagnosis and continued symptoms, a short course of chiropractic treatment would appear to be reasonable. In this case, the treater has requested an initial trial of 12 treatments, which exceeds what is recommended by MTUS. Therefore, the request is not medically necessary.