

<b>Case Number:</b>	CM15-0089325		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	02/24/2003
<b>Decision Date:</b>	06/19/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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: New York, Tennessee  
 Certification(s)/Specialty: Emergency Medicine

### 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 56 year old male patient who sustained an industrial injury on 02/24/2003. The patient underwent intraspinal pump placement on 11/04/2014. He had subjective complaint of "I'm sick to my stomach and have abdominal pain." "The little toe on my right foot is numb and my neck and upper extremities hurt". He was diagnosed with: failed back surgery syndrome with intractable low back pain and bilateral lower extremity pain associated with numbness to the right little toe; abdominal pain acute; neck pain, nonindustrial; intrathecal and oral Opioid therapy with unsatisfactory analgesia. The plan of care noted the patient to follow up with gastroenterologist, pump refill and reprogramming, refilling medications Percocet, Skelaxin, Lyrica, and follow up in 2 weeks. A visit dated 12/18/2014 reported the patient having had fallen in the mud with no apparent injury. He is complaining of some increased low back pain, but appears comfortable. The last urine screening results were consistent with prescribed medications. Chronic nausea was added to the treating diagnoses.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Referral to Rectal specialist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate: Diagnostic approach to abdominal pain in adults.

**Decision rationale:** Chronic abdominal pain is a common complaint, and the vast majority of patients will have a functional disorder. Although patients with apparently functional abdominal pain have normal investigations and a benign prognosis, they often respond with dissatisfaction and distrust towards physicians who tell them that "nothing is wrong." Functional bowel diseases are associated with diminished quality of life, work loss, and morbidity, and patients deserve attentive trials of therapy as described elsewhere. Conversely, a diagnosis of new-onset functional illness should be made only with great caution in patients over 50 years of age. These patients, by virtue of their increased risk of malignancy, will likely require abdominal imaging with ultrasound or CT and upper gastrointestinal tract endoscopy and/or colonoscopy as their symptoms and signs dictate. Many patients in this age group should have colonoscopy performed for screening purposes independent of symptoms, if this has not been performed previously. In this case the patient has been seen by neurogastroenterologist who opined that the etiology of the patient's GI symptoms was the patient's medication. Documentation does not support the necessity for surgical intervention. The request is not medically necessary.

**Radiofrequency levels, C4-C5, C5-C6, C6-C7:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & 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: Low Back, Lumbar & Thoracic, Facet joint radiofrequency neurotomy or rhizotomy.

**Decision rationale:** Facet joint radiofrequency neurotomy or rhizotomy is 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. (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. In this case the diagnosis of facet joint pain is not supported by the documentation in the medical record. In addition the request for 3 levels of treatment surpasses the recommended maximum of two levels. The request is not medically necessary.