

Case Number:	CM14-0044327		
Date Assigned:	07/02/2014	Date of Injury:	08/10/2008
Decision Date:	08/27/2014	UR Denial Date:	04/03/2014
Priority:	Standard	Application Received:	04/11/2014

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 and is licensed to practice in Texas and Ohio. 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 43-year-old male who reported an injury on 08/10/2008. The mechanism of injury was not provided. On 04/14/2014 the injured worker presented with low back pain. Upon examination there was a prominent infraspinatus trigger point located in the middle scapula and 5 trigger points over the medial border of the scapula. Examination of the low back revealed pain with extension and rotation at the lumbar spine to the left side. There was tenderness to palpation over the left L4-5 and L5-S1 facet joints. There was a negative straight leg raise. The diagnoses were cervical facet pain, left lumbar facet pain involving L4-5 and L5-S1 and left scapulocostal syndrome. Prior therapy included medications. The provider recommended a radiofrequency ablation to the left L4-5 and L5-S1. The provider's rationale was not provided. The Request for Authorization form was dated 03/27/2014. Medical records from 2012 to 2013 were reviewed. Patient complained of worsening pain at the left arm, forearm, shoulder, and neck of moderate to severe intensity. Patient denied numbness, tingling sensation, or instability. Popping sensation was noted at the left elbow. Aggravating factors included carrying, pushing / pulling, grasping, and squeezing. Patient's height is 5'4, weighs 268 pounds, with body mass index of 46 kg/m². Physical examination revealed tenderness at the cervical spine and right shoulder. Left shoulder showed limited range of motion, weakness, positive SLAP test, positive Hawkin's test, and positive impingement test. Range of motion of the elbow was from zero to 125 degrees. Forearm pronation and supination were both measured at 90 degrees. Right knee range of motion was measured at 10 to 95 degrees; left knee from zero to 95 degrees. Left upper extremity reflexes were brisk. The MRI of the left elbow, dated 03/22/2013, showed that evaluation was fairly limited due to patient's size, magnet field strength and motion artifact. A small joint effusion was present. There may be a small focus of subchondral edema in the radial head but no fracture was noted. No definite ligamentous or tendinous injury was

seen. MRI of the left shoulder, dated 03/22/2013, revealed partial thickness tear of the leading edge of supraspinatus tendon. Evaluation was fairly limited by motion artifact. Treatment to date has included left total knee replacement in 2012, left shoulder cortisone injection, physical therapy, weight loss program, and medications such as tramadol and meloxicam. Previous utilization review from 10/10/2013 was not made available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radio frequency Ablation :left L4-5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301, Chronic Pain Treatment Guidelines Radiofrequency Ablation Page(s): 102. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet Joint Radiofrequency Neurotomy.

Decision rationale: The request for a radiofrequency ablation left L4-5 and L5-S1 is not medically necessary. The California MTUS/ACOEM Guidelines state there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provide good temporary relief of pain. However, similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produced mixed results. Additionally, the Official Disability Guidelines state facet joint neurotomies or ablations are under study. The criteria for use for a facet joint neurotomy or ablation in the lumbar area include a diagnosis of facet joint pain using a medial branch block, repeat neurotomies may be required, but should not occur at intervals of less than 6 months from the first procedure and is documented for at least 12 weeks at a greater than or equal to 50% relief of pain. Approval for repeat neurotomies depend on evidence of adequate diagnostic blocks, documented improvement in VAS scores, decreased medications and documented improvement in function. Submitted documentation lacks evidence of objective functional improvement, decrease in pain medications and an improved VAS score. There is also lack of documentation of at least greater than or equal to 50% of relief of pain with the prior neurotomy and documentation of decreased medications. As such, the request is not medically necessary.