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| Case Number: | CM14-0212971 | | |
| Date Assigned: | 12/30/2014 | Date of Injury: | 05/21/2013 |
| Decision Date: | 02/27/2015 | UR Denial Date: | 12/15/2014 |
| Priority: | Standard | Application Received: | 12/19/2014 |

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. 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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative 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 60-year-old gentleman with a date of injury of 05/21/2013. A treating physician note dated 12/09/2014 identified the mechanism of injury as a fall, resulting in head, neck, and lower back pain. This note indicated the worker was experiencing lower back pain, left hip pain, right neck pain that went into both shoulders, and left elbow pain. Documented examinations consistently described decreased motion in the upper back joints, tenderness with spasm in the upper and lower back muscles, positive facet loading testing, a C4 and C5 facet pain pattern, a straightened lower back curve, decreased lower back joint motion, positive FABER testing, and tenderness in the left hip. The submitted and reviewed documentation concluded the worker was suffering from cervicalgia, cervicobrachial syndrome, lumbago, lumbar disc displacement, and muscle spasm. Treatment recommendations included medications, physical therapy, medications injected in the back, TENS, random urinary drug screen testing, and radiofrequency ablation in the upper back. A Utilization Review decision was rendered on 12/15/2014 recommending non-certification for radiofrequency ablation at the right C4-5 and C5-6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency ablation and right C4-5: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, Acute and Chronic (updated 11/18/14)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Soloman M, et al. Radiofrequency Treatment in chronic pain. Expert Rev Neurother. 2010; 10(3): 469-474. Medscape, accessed 02/18/2015. http://www.medscape.com/viewarticle/718292_3

Decision rationale: The ACOEM Guidelines in general support the use of radiofrequency ablation for the temporary relief of pain in the upper back. There is limited literature to support this treatment. However, studies have shown mixed results from this treatment for the lower back, and the Guidelines in general do not support it in that setting, especially without investigational dorsal ramus medial branch diagnostic blocks performed first. The submitted and reviewed documentation concluded the worker was suffering from cervicalgia, cervicobrachial syndrome, lumbago, lumbar disc displacement, and muscle spasm. The worker continued to have symptoms despite conservative treatments. The goal of this treatment was to improve function and participation in the home exercise program. For these reasons, the current request for radiofrequency ablation at the right C4-5 is medically necessary.

Radiofrequency ablation at right C5-6: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, Acute and Chronic (updated 11/18/14)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Soloman M, et al. Radiofrequency treatment in chronic pain. Expert Rev Neurother. 2010; 10(3): 469-474. Medscape, accessed 02/18/2015. http://www.medscape.com/viewarticle/718292_3

Decision rationale: The ACOEM Guidelines in general support the use of radiofrequency ablation for the temporary relief of pain in the upper back. There is limited literature to support this treatment. However, studies have shown mixed results from this treatment for the lower back, and the Guidelines in general do not support it in that setting, especially without investigational dorsal ramus medial branch diagnostic blocks performed first. The submitted and reviewed documentation concluded the worker was suffering from cervicalgia, cervicobrachial syndrome, lumbago, lumbar disc displacement, and muscle spasm. The worker continued to have symptoms despite conservative treatments. The goal of this treatment was to improve function and participation in the home exercise program. For these reasons, the current request for radiofrequency ablation at the right C5-6 is medically necessary.

