

Case Number:	CM14-0213668		
Date Assigned:	12/31/2014	Date of Injury:	01/26/2010
Decision Date:	02/25/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	12/22/2014

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: California

Certification(s)/Specialty: Physical Medicine & Rehabn

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 patient is a 61 year old male with an injury date of 01/26/10. The patient is status post right wrist carpal tunnel in 02/14, as per progress report dated 11/11/14. As per progress report dated 12/10/14, the patient complains of intermittent, sharp, stabbing pain in the lower back rated at 6.5/10. Rest and sitting alleviate the symptoms while changing positions exacerbates them. The patient also suffers from headaches and neck pain. Physical examination reveals severe tenderness in the lower lumbar spine along with moderately decreased range of motion. Kemp's test is positive bilaterally. In progress report dated 11/11/14, the patient complains of neck pain that radiates only slightly to the scapula. The patient underwent radio-frequency lesioning at C5, C6 and C7 medial branch nerves on 10/27/14 which led to a complete relief of his pain. The cervical pain is rated at 1/10 in the report. Physical examination reveals cervical muscle spasticity at C7-T1 left paraspinal musculature along with a circumscribed trigger point with a twitch response. Medications, as per progress report dated 11/11/14, include Zofran, Cyclobenzaprine, Lisinopril, Meloxicam and Omeprazole. The patient also underwent interval medial branch block at C5, C6 and C7 on 07/29/14 which led to 90-95% pain relief. The patient has failed physical therapy, chiropractic treatment, trigger point injections, and anti-inflammatory medications, as per progress report dated 04/09/14. MRI of the Lumbar Spine, 02/09/14:- Multilevel advanced degenerative disc disease at all levels but more severe at L3-4 through L5-S1 along with facet arthritic changes and varying degrees of foraminal and lateral recess stenosis.- Postoperative changes of right laminectomy L4-5 Diagnoses, 12/10/14:- Myofascial pain- Cervicalgia- Cervical degenerative disc disease- Cervical spondylosis with

myelopathy- Lumbosacral spondylosis- Back painThe utilization review determination being challenged is dated 12/17/14. Treatment reports were provided from 02/09/14 - 12/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Radiofrequency Ablation L3-4, L4-5, L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic chapter, Facet joint radiofrequency neurotomy.

Decision rationale: The patient presents with intermittent, sharp, stabbing pain in the lower back, rated at 6.5/10, along with severe tenderness in the lower lumbar spine along with moderately decreased range of motion, as per progress report dated 12/10/14. The request is for bilateral radiofrequency ablation AT L3-4, L4-5, and L5-S1. ACOEM guidelines, chapter 8 page 174 incidentally notes under foot note: "There is limited evidence that radio-frequency neurotomy may be effective in relieving or reducing cervical facet joint pain among patients who had a positive response to facet injections. Lasting relief (eight to nine months, on average) from chronic neck pain has been achieved in about 60% of cases across two studies, with an effective success rate on repeat procedures, even though sample sizes generally have been limited (n=24,28). Caution is needed due to the scarcity of high-quality studies." ODG guidelines support it for facet joint syndrome after proper diagnostics have been carried out. For repeat procedure, greater than 50% reduction of pain lasting at least 3 months and if not 6 months is required. In progress report dated 05/07/14, the treater stated that the patient had received RFA (level not mentioned) 10.5 months ago which provided relief for almost 10 months. The treater, therefore, requested for RFA bilateral L3-4 to L5-S1. The patient underwent the procedure on 05/10/14, as per the operative report. In progress report dated 12/10/14, the treater requests for another RFA at L3-4, L4-5 and L5-S1 bilaterally as it has been 7 months since the last procedure. The treater states that "These have been allowing him to function for 6-12 months." While ODG guidelines support repeat procedures if the duration of symptom reduction lasts for at least 3-6 months, the treater does not specifically document a 50% reduction in pain, no significant changes in function or reduction of medication use. Furthermore, ODG recommends treatments at no more than two levels bilaterally, and the request is for three levels bilaterally. Hence, this request is not medically necessary.