MAXIMUS Federal Services

Case Number:	CM15-0128993		
Date Assigned:	07/15/2015	Date of Injury:	08/09/2012
Decision Date:	08/18/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	07/02/2015

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: Illinois, California, Texas
Certification(s)/Specialty: Orthopedic Surgery

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 47-year-old male who sustained an industrial injury on 8/9/12. Injury occurred when he was lifting a gurney with a body weighing over 300 pounds. Past medical history was positive for hypertension, diverticulosis/diverticulitis, basal cell cancer, melanoma, and hypertension. Conservative treatment included muscle relaxants, anti-inflammatory drugs, physical therapy, acupuncture, pain medications, topical analgesic patches, Toradol and vitamin B12 injections, and work modifications. Right L4 and L5 medial branch radiofrequency neurolysis was performed on 8/26/14 and right S2, S3, and S4 medial branch radiofrequency neurolysis was performed on 11/18/14. Records did not document a specific reduction in pain, reduction in pain medication, or improved function to radiofrequency ablation. Benefit was documented generically to the treatment regime, including medications, physical therapy, and acupuncture. The 6/19/15 treating physician report cited a chief complaint of low back, bilateral lower extremity, and right buttock pain. Pain was exacerbated by increased activity and lifting. Pain was appreciably lessened and functional ability increased by his current treatment regime. Current medications included Lidoderm patches, omeprazole, Meloxicam, Norco, cyclobenzaprine, and Lyrica. He reported that pain was 7/10 and requested injection therapy. He reported that right hip and lumbar radiofrequency ablation had given him 75% relief for 7 months. He was not able to walk or sit for long periods of time like he used to and activities were getting difficult. Physical exam documented palpable taut bands in the area of pain with soft tissue dysfunction and spasms in the lumbar paraspinal, gluteal and lower extremity region. Straight leg raise was positive. Compression of the pelvis produced concordant pain to the buttocks. Coordination appears to be somewhat compromised and Romberg tests was abnormal. The diagnosis included lumbosacral spondylosis without myelopathy, lumbar disc displacement

without myelopathy, myalgia/myositis, sleep disturbance, sacroiliitis, and lumbago. Authorization was requested for radiofrequency ablation at right S2, right S3, right S4, and right L4/5, and Norco was increased. The 6/26/15 utilization review denied the request for radiofrequency ablation at right S2, right S3, right S4, and right L4/5 as the injured worker had not had a prior diagnostic medial branch block to these levels and no more than 2 joint levels are to be performed at one time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right S2 Radiofrequency Ablation QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG Low Back (updated 5/15/2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis: Sacroiliac joint radiofrequency neurotomy.

Decision rationale: The California MTUS guidelines do not provide recommendations for sacroiliac joint radiofrequency rhizotomy. The Official Disability Guidelines state that sacroiliac joint radiofrequency neurotomy is not recommended. Evidence is limited for this procedure and the use of all sacroiliac radiofrequency techniques has been questioned, in part, due to the fact that the innervation of the sacroiliac joint remains unclear. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. Guideline criteria have not been met. This injured worker underwent right S2, S3, and S4 radiofrequency ablation on 11/18/14. There is no documentation of prior diagnostic medial branch blocks. There is no documentation since 11/18/14 relative to specific VAS improvement, decreased medication use, or improvement in objective functional ability specific to the prior right S2, S3, and S4 injections. Generic benefit is documented to the treatment regime, which includes on-going medication. Guidelines do not support radiofrequency ablation at more than 2 levels or for the sacroiliac joint. Therefore, this request is not medically necessary.

Right S3 Radiofrequency Ablation QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG Low Back (updated 5/15/2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis: Sacroiliac joint radiofrequency neurotomy.

Decision rationale: The California MTUS guidelines do not provide recommendations for sacroiliac joint radiofrequency rhizotomy. The Official Disability Guidelines state that sacroiliac joint radiofrequency neurotomy is not recommended. Evidence is limited for this procedure and the use of all sacroiliac radiofrequency techniques has been questioned, in part, due to the fact that the innervation of the sacroiliac joint remains unclear. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. Guideline criteria have not been met. This injured worker underwent right S2, S3, and S4 radiofrequency ablation on 11/18/14. There is no documentation of prior diagnostic medial branch blocks. There is no documentation since 11/18/14 relative to specific VAS improvement, decreased medication use, or improvement in objective functional ability specific to the prior right S2, S3, and S4 injections. Generic benefit is documented to the treatment regime, which includes on-going medication. Guidelines do not support radiofrequency ablation at more than 2 levels or for the sacroiliac joint. Therefore, this request is not medically necessary.

Right S4 Radiofrequency Ablation QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG Low Back (updated 5/15/2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis: Sacroiliac joint radiofrequency neurotomy.

Decision rationale: The California MTUS guidelines do not provide recommendations for sacroiliac joint radiofrequency rhizotomy. The Official Disability Guidelines state that sacroiliac joint radiofrequency neurotomy is not recommended. Evidence is limited for this procedure and the use of all sacroiliac radiofrequency techniques has been questioned, in part, due to the fact that the innervation of the sacroiliac joint remains unclear. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. Guideline criteria have not been met. This injured worker underwent right S2, S3, and S4 radiofrequency ablation on 11/18/14. There is no documentation of prior diagnostic medial branch blocks. There is no documentation since 11/18/14 relative to specific VAS improvement, decreased medication use, or improvement in objective functional ability specific to the prior right S2, S3, and S4 injections. Generic benefit is documented to the treatment regime, which includes on-going medication. Guidelines do not support radiofrequency ablation at more than 2 levels or for the sacroiliac joint. Therefore, this request is not medically necessary.

Right L4-5 Radiofrequency Ablation QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG Low Back (updated 5/15/2015).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Facet joint radiofrequency neurotomy.

Decision rationale: The California MTUS guidelines state that facet neurotomies are under study and should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The Official Disability Guidelines indicate that facet joint radiofrequency ablation (neurotomy, rhizotomy) is under study. Treatment requires a diagnosis of facet joint pain using one set of diagnostic medial branch blocks with a response of 70%. Criteria state that 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). 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. There should be evidence of a formal plan of additional evidenced based conservative care in addition to facet joint therapy. Guideline criteria have not been met. This injured worker underwent right L4 and L5 radiofrequency ablation in April 2014, and subsequent right S2, S3, and S4 radiofrequency ablation in November 2014. There is no documentation of prior diagnostic medial branch blocks. The available records do not predate the most recent injections or provide documentation of specific VAS improvement, decreased medications, or improvement in objective functional ability following the L4/5 injections. Generic benefit to the treatment regime, including on-going medication, is documented in the progress reports. Additionally, there is no current diagnosis or clinical exam finding consistent with facet mediated pain. Therefore, this request is not medically necessary.