MAXIMUS Federal Services

Case Number:	CM15-0178067		
Date Assigned:	09/18/2015	Date of Injury:	06/20/2012
Decision Date:	11/06/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/10/2015

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
Certification(s)/Specialty: Anesthesiology

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 male, who sustained an industrial injury on 6-20-2012. The medical records indicate that the injured worker is undergoing treatment for lumbar spine disc bulge, status post lumbar laminectomy and discectomy (9-1-2013), spinal stenosis and facet joint arthrosis of the lumbar spine, and mild right-sided L4 and L5 radiculopathy and foot drop. According to the progress report dated 8-18-2015, the injured worker complains of increased pain and spasm to his right lower lumbar area. He describes the pain as very sharp and gnawing. The level of pain is not rated. He notes that he has significant weakness to his right lower extremity with intermittent right foot drop. The physical examination of the lumbar spine reveals increased spasm to the right lower lumbar region. He notes significant pain with motion. Range of motion is 45 degrees with flexion, 20 degrees with extension, and 20 degrees with right and left lateral bend. There is increased paraspinal tenderness on the right side. Lasegue's test is positive on the right. There is decreased sensation to the dorsal aspect of the right foot and first toe. The current medications are Ibuprofen, Soma, Tramadol, and Voltaren gel. Treatment to date has included medication management, MRI studies, injection, lumbar facet blocks, and surgical intervention. MRI from 5-15-2015 shows 4-millimeter midline and paracentral disc protrusion (L2-L3) with abutment of the descending left L3 nerve root. There is a 3-millimeter circumferential disc protrusion (L3-L4) resulting in abutment of the descending L4 nerve roots bilaterally with a mild degree of central canal narrowing. There is a 5-millimeter circumferential disc protrusion (L4-L5) with abutment of the descending L5 nerve roots bilaterally, as well as abutment of the exiting right and left nerve roots. There is a 4-millimeter circumferential disc

protrusion (L5-S1) with abutment of the descending S1 nerve roots bilaterally, as well as abutment of the exiting right and left L5 nerve roots. Work status is described as modified duties. The original utilization review (8-26-2015) had non-certified a request for bilateral radiofrequency ablation L4, L5, and S1 and follow-up visit after procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency ablation L4 bilateral: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Radiofrequency Ablation.

Decision rationale: Medial branch blocks (MBBs) and radiofrequency ablations (RFA) are accepted pain management interventional techniques. However, specific criteria and standards of care apply for performing these procedures. According to the ODG, the criteria for the use of therapeutic MBBs are as follows: 1) no more than one therapeutic intra-articular block is recommended. 2) There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3) If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of 6 weeks) the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the MBB is positive). 4. No more than 2 joint levels may be blocked at any one time. In this case, the patient has radicular pain and does not meet the ODG recommendations for facet joint blocks or to be subsequently followed by facet joint rhizotomy (or radiofrequency neurotomy). Medical necessity for the requested RFA bilateral L4 has not been established. The requested procedure is not medically necessary.

Radiofrequency ablation L5 bilateral: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Radiofrequency Ablation.

Decision rationale: Medial branch blocks (MBBs) and radiofrequency ablations (RFA) are accepted pain management interventional techniques. However, specific criteria and standards of care apply for performing these procedures. According to the ODG, the criteria for the use of therapeutic MBBs are as follows: 1) no more than one therapeutic intra-articular block is recommended. 2) There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3) If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of 6 weeks) the recommendation is to proceed to a medial branch diagnostic block and

subsequent neurotomy (if the MBB is positive). 4. No more than 2 joint levels may be blocked at any one time. In this case, the patient has radicular pain and does not meet the ODG recommendations for facet joint blocks or to be subsequently followed by facet joint rhizotomy (or radiofrequency neurotomy). Medical necessity for the requested RFA bilateral L5 has not been established. The requested procedure is not medically necessary. The requested procedure is not medically necessary.

Radiofrequency ablation S1 bilateral: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Radiofrequency Ablation.

Decision rationale: Medial branch blocks (MBBs) and radiofrequency ablations (RFA) are accepted pain management interventional techniques. However, specific criteria and standards of care apply for performing these procedures. According to the ODG, the criteria for the use of therapeutic MBBs are as follows: 1) no more than one therapeutic intra-articular block is recommended. 2) There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3) If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of 6 weeks) the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the MBB is positive). 4. No more than 2 joint levels may be blocked at any one time. In this case, the patient has radicular pain and does not meet the ODG recommendations for facet joint blocks or to be subsequently followed by facet joint rhizotomy (or radiofrequency neurotomy). Medical necessity for the requested RFA bilateral S1 has not been established. The requested procedure is not medically necessary.

Office visit follow up after procedure: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.