

Case Number:	CM15-0178429		
Date Assigned:	09/18/2015	Date of Injury:	10/14/2009
Decision Date:	10/22/2015	UR Denial Date:	08/20/2015
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: 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 43-year-old female who sustained an industrial injury on 10/14/09. Injury occurred relative to a trip and fall, landing on her right knee. She was status post 3 right knee surgeries. The 2/5/14 lumbar spine x-ray impression documented mild lumbar levoscoliosis. The 7/21/14 lumbar spine MRI impression documented an L4/5 annular bulge with bilateral annular fissures, mild facet and ligamentum flavum hypertrophy, and mild to moderate foraminal stenosis with mild central canal stenosis. At L2/3, there was 4 mm left foraminal protrusion with mild left foraminal stenosis. At L3/4, there was a small annular bulge and left lateral annular fissure. There was mild facet hypertrophy noted at L5/S1. The injured worker underwent right L4/5 and L5/S1 medial branch blocks and diagnostic right sacroiliac joint injection on 6/15/15 and 7/1/15. The 8/10/15 pain management report indicated that the medial branch block provided at most 10% relief. She attended two sessions of physical therapy and stopped going. She had 8 sessions of psychotherapy and behavioral therapy approved but had not been able to schedule and this was due to expire 8/29/15. Subjective complaints included constant grade 6-7/10 right sided low back pain and right knee pain. Lumbar spine exam documented restricted and painful range of motion, paravertebral muscle tenderness and spasms, normal heel and toe walk, and negative straight leg raise. Waddell's sign was positive. Pelvic compression test was positive. There were spasms noted over the right sacroiliac joint and right L5/S1 and L4/5 facet joints. Lower extremity neurologic exam was within normal limits. Right provocative facet maneuvers were positive. The diagnosis was lumbar disc displacement without myelopathy, thoracic or lumbosacral neuritis/radiculitis, and lumbago. The pain management

physician indicated that the diagnostic right L4/5 and L5/S1 medial branch block and right sacroiliac joint injection did not provide relief, nor did the 3 previous epidural injections. The treatment plan recommends psychological referral and continued physical therapy. Medications were prescribed to include Neurontin, Cymbalta, and Tramadol. The 8/13/15 treating physician report indicated that the injured worker had 24-48 hours of very good relief of her pain with facet blocks and then recurring pain. Authorization was requested for radiofrequency ablation at right L4/5 and L5/S1. The 8/20/15 utilization review non-certified the request for right L4/5 and L5/S1 radiofrequency ablation as there was no clear evidence that the injured worker had a positive response to the medial branch block consistent with guidelines, or that she received adequate conservative treatment following the medial branch block, or that additional evidence based conservative treatment was planned in addition to facet joint therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency ablation at the right L4-L5 and L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Facet joint diagnostic blocks (injections); 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%. The pain response should last at least 2 hours for Lidocaine. There should be evidence of a formal plan of additional evidenced based conservative care in addition to facet joint therapy. The ODG do not recommended facet joint diagnostic blocks for patients with radicular low back pain. Guideline criteria have not been met. This injured worker presents with right sided low back pain. She underwent right L4/5 and L5/S1 medial branch blocks on 6/15/15 with no more than 10% relief according to the pain management physician who provided the injections. This response does not meet guideline criteria to proceed with radiofrequency ablation. Therefore, this request is not medically necessary.