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| Case Number: | CM15-0093866 | | |
| Date Assigned: | 05/20/2015 | Date of Injury: | 05/15/2014 |
| Decision Date: | 06/24/2015 | UR Denial Date: | 04/23/2015 |
| Priority: | Standard | Application Received: | 05/15/2015 |

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:

The injured worker is a 61-year-old female who sustained an industrial injury on 5/15/14. The mechanism of injury was not documented. Records documented significant low back pain radiating into both lower extremities. She was diagnosed with multilevel lumbar spondylosis with bilateral sacroiliac joint dysfunction, hypertension, depression, and sleep dysfunction. Initial treatment included physical therapy, recommended weight loss, home exercise program, work restrictions, and medications. Sacroiliac joint injections were reported as temporarily beneficial with minimal residual left low back pain and 25-30% improvement on the right. The 2/16/15 lumbar spine MRI impression documented multilevel severe disc disease and facet arthropathy with levoscoliosis and retrolisthesis L1/2 through L5/S1 with marked endplate vertebral body edema, and moderate L3/4 and mild to moderate L4/5 canal stenosis. There was moderate to severe bilateral L3/4, severe left and moderate right L4/5, and severe left L5/S1 neuroforaminal narrowing contacting the exiting nerve root. There was an L2/3 central and right lateral disc protrusion, and an L3/4 central protrusion/extrusion with facet arthropathy and contact of the left L3 nerve root. At L4/5, there was a left disc protrusion and extrusion with severe foraminal narrowing and contact of the left nerve root. At L5/S1, there was a central left paracentral disc protrusion/extrusion displacing the left S1 nerve root, severe left foraminal narrowing, and contact of the left L5 nerve root. The 4/15/15 treating physician report cited grade 8/10 lower back pain. She underwent medial branch blocks on 3/31/15 with near 100% pain relief for the duration of the local anesthetic and wished to move forward with radio-frequency ablation. Current medications included Vicodin, cyclobenzaprine, trazodone, and

fenoprofen. Sitting tolerance was limited to 2 hours. Standing and walking tolerance was limited to 15 minutes. Physical exam documented normal gait, full lower extremity strength and sensation, and positive bilateral lumbar facet loading. The impression included multilevel severe disc disease, facet arthropathy, retrolisthesis, and marked endplate/vertebral body edema with moderate central stenosis at L3/4 and L4/5, and moderate to severe L3/4 bilateral foraminal narrowing, severe left and moderate right L4/5 foraminal narrowing, and severe left L5/S1 foraminal narrowing with contact of the left L3, L4, L5, and S1 nerve roots, and lumbar facet syndrome. The treatment plan requested authorization for bilateral L3 through L5 radio-frequency ablation. The injured worker was to continue her home exercise program, weight loss, and current medications, and follow-up in one month. A trial of Cymbalta was prescribed. The 4/23/15 utilization review non-certified the request for bilateral L3 L4 L5 radiofrequency ablation based on insufficient clinical information, including mechanical of injury, comprehensive assessment of treatment completed to date and response thereto, and limited physical exam documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L3 L4 L5 radiofrequency ablation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

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 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 patient presents with significant low back pain and a history of radicular symptoms. There was significant benefit noted with recent medial branch blocks. However, there is imaging evidence of multilevel severe degenerative disc disease and facet arthropathy with moderate to severe neuroforaminal narrowing at the L3-L5 levels and contact with the left L3-S1 nerve roots. Given the recent history of radicular low back pain consistent with imaging evidence, this request would not be supported by guidelines. Therefore, this request is not medically necessary.