

<b>Case Number:</b>	CM13-0010586		
<b>Date Assigned:</b>	09/23/2013	<b>Date of Injury:</b>	12/15/2008
<b>Decision Date:</b>	01/22/2014	<b>UR Denial Date:</b>	08/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 47-year-old male who sustained an industrial injury on 12/15/2008. He was diagnosed with having a lumbar spine sprain and strain, a 3 mm disc bulge with stenosis at L4-S1 and degenerative disc disease at L3-S1. The patient has had a previous lumbar facet rhizotomy performed at the L4-S1 levels, which apparently gave him 100% axial pain relief for approximately 18 months. However, according to the documentation, the patient underwent a lumbar epidural steroid injection that was repeated 5 months after the radiofrequency ablation treatment. Therefore, it was unclear which procedure actually provided the patient with his reported 100% pain relief. The patient has also included other treatment modalities to include chiropractic treatment and home exercises. He stated that these efforts were unsuccessful in treating his back pain. The physician is now requesting a bilateral L4-S1 medial branch facet joint rhizotomy/neurolysis, and a hot and cold unit for postoperative treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral L4-S1 medial branch facet joint rhizotomy/neurolysis:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG-TWC

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

**Decision rationale:** According to California MTUS/ACOEM, radiofrequency neurotomy is considered a treatment for select patients with low back pain. There is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Official Disability Guidelines were also referred to in this case. Official Disability Guidelines states that while repeat neurotomies may be required, they should not occur in an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at greater than or equal to 50% relief. The patient underwent a previous rhizotomy at the same levels being requested with a reported 100% pain relief for approximately 18 months. However, because the patient also underwent an epidural steroid injection roughly 5 months after the rhizotomy performed, it is unclear if the patient actually sustained 50% or greater pain relief with the results of the neurotomy. Therefore, it is unclear which procedure was more effective. Without accurate information documenting that the previous rhizotomy was effective, a repeat neurotomy at this time is not warranted for this patient. As such, the requested service is non-certified.

**Hot/Cold unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG-TWC

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

**Decision rationale:** Official Disability Guidelines (ODG) Low Back Chapter, Cold/heat packs