

<b>Case Number:</b>	CM13-0036337		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	10/25/1986
<b>Decision Date:</b>	02/07/2014	<b>UR Denial Date:</b>	09/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2013

### 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 Anesthesia, has a subspecialty in Acupuncture and Pain Medicine and is licensed to practice in California. 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 injured worker is a 57 year old male with a date of injury of October 25, 1986 with related low back pain that was previously under control with prior rhizotomy. The injured worker is status post L4-L5 laminectomy and fusion from 1990; cervical fusion of C4 to C6 in 1991. The injured worker had an electromyography and nerve conduction velocity in 2006 that revealed severe right and left motor neuropathy, C5, C6, and C7 radiculopathy, and L4 and L5 radiculopathy bilaterally. Between 2007 and 2010 the injured worker underwent several procedures such as bilateral lumbar median branch blocks and cervical diagnostic facet blocks. In 2011 the injured worker had lumbar and cervical bilateral rhizotomies. In 2012 the injured worker had a three-level bilateral cervical rhizotomy. In July 2012 the injured worker had a cervical MRI, which showed unchanged anterior fusion of the cervical spine and mild anterior flattening and disc bulge at C3-C4. The injured worker had a three-level bilateral lumbar rhizotomy in December 2012. The injured worker has been treated with physical therapy, prolotherapy, blocks, epidural injections, surgery, and medications. The date of UR decision was September 16, 2013

### IMR ISSUES, DECISIONS AND RATIONALES

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

**The request for a fluoroscopic lumbar rhizotomy to the bilateral L2-L3 and L3-L4: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

**Decision rationale:** According to the California MTUS ACOEM Guidelines, "Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks" but beyond that MTUS is silent on specific requirements for radiofrequency (RF) ablation in the lumbar spine. The ODG indicates that criteria for facet joint radiofrequency neurotomy are as follows: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block. (2) While repeat neurotomies may be required, they should not occur at 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  $\geq$  50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. (3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in visual analogue scale (VAS) score, decreased medications and documented improvement in function. (4) No more than two joint levels are to be performed at one time. (5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. (6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. The documentation submitted for review does not include evidence of adequate diagnostic blocks at the L2-L3 and L3-L4 levels, per criteria 3, even with repeat neurotomies there should be evidence of adequate diagnostic blocks prior to the consideration of repeat neurotomy. Additionally, the documentation is lacking a formal plan of additional evidence-based conservative care in addition to facet joint therapy to meet accordance with criteria 6. As such, the request is not medically necessary.