

Case Number:	CM13-0049458		
Date Assigned:	12/27/2013	Date of Injury:	12/21/1998
Decision Date:	04/25/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	11/07/2013

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. The expert reviewer is Board Certified in Anesthesiology & Pain Management and is licensed to practice in Florida. 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/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 51-year-old female who reported an injury on 12/21/1998. The mechanism of injury was not provided. The clinical documentation of 09/22/2013 revealed that the letter was for an appeal purpose. It was noted that the patient had an RFA on 05/09/2012 at the levels of bilateral L3-5. The patient had 8 months of relief with a 70% pain reduction. The recent documentation indicated that the patient's pain and medication use had increased, and her function had decreased due to the non-certification. The documentation of 10/16/2013 revealed that the patient had low back pain radiating down the left leg and occasionally on the right with some associated numbness and tingling. The patient indicated that the subjective complaints were not any different. Physical examination revealed that the patient had no lower extremity weakness or atrophy. The patient had patchy hypoesthesia and hypalgesia in the left leg. The electrodiagnostic testing revealed a normal electromyogram of the bilateral lower extremities and normal motor and sensory conduction studies of the lower extremities as well as normal H-reflexes. There was no evidence of lumbosacral motor root compression, lumbar plexopathy, peripheral entrapment/compression neuropathy or generalized polyneuropathy. The physician opined that the patient should have the facet blocks. He further stated that the use of facet block injections had provided lasting relief on multiple occasions. The patient indicated that she received radiofrequency ablations 1 to 2 times a year with 5 to 6 months of relief. The request was made for a bilateral lumbar medial branch nerve radiofrequency neurotomy at L3, L4 and L5.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL LUMBAR MEDIAL BRANCH NERVE RADIOFREQUENCY NEUROTOMY AT L3, L4, L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 30. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), LOW BACK CHAPTER, FACET JOINT RADIOFREQUENCY NEUROTOMY

Decision rationale: ACOEM Guidelines indicate that radiofrequency neurotomy for the treatment of select patients with low back pain is recommended. As there was a lack of criteria for the use of neurotomies, secondary guidelines were sought. The Official Disability Guidelines indicate radiofrequency neurotomies are under study. However the criteria for the use of diagnostic blocks if requested indicates that the patient should have facet-mediated pain which includes tenderness to palpation in the paravertebral area over the facet region, a normal sensory examination, absence of radicular findings and a normal straight leg raise exam. Additionally, one set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally. Official Disability Guidelines recommends for repeat neurotomies that the patient had documentation of a duration of relief from the first procedure for at least 12 weeks at \geq 50% relief. Additionally, the approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. Also, there should be a formal plan of additional evidence-based conservative care in addition to facet joint therapy. The clinical documentation submitted for review indicated that the patient had 8 months of relief of 70% pain reduction. However, there was a lack of documentation indicating that the patient had a documented improvement in the VAS and an objective decrease in medication usage as well as objective improvement in function. There was a lack of documentation indicating that the patient had a formal plan of evidence-based conservative care in addition to the facet joint therapy. The clinical documentation failed to include the original request. There was a lack of documentation indicating that the patient had facet-mediated pain with tenderness to palpation over the paravertebral area and a normal straight leg raise exam. Given the above, the request for bilateral lumbar medial branch nerve radiofrequency neurotomy at L3, L4 and L5 is not medically necessary.