

<b>Case Number:</b>	CM13-0059932		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	09/05/2008
<b>Decision Date:</b>	06/04/2014	<b>UR Denial Date:</b>	11/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 Orthopedic Surgery, 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 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 53year old female who was injured on 09/05/2008. She was assaulted by a psychiatric patient while working as a psychiatric technologist. She has right hip and low back pain. Prior treatment history has included MBB on 02/01/2013 with 90% relief for over 3 days status post RFA on March 1st, with 80% pain relief. The patient was noted to be taking Norco 6-8 daily, including 1-2 pills in the middle of the night. The patient is status post total hip replacement. Visit note dated 12/13/2013 indicated the patient continues with complaints of ongoing right hip and low back pain stemming from a work-related incident. She rates her pain as an 8-9/10 and would like another RFA. Objective findings on exam revealed tenderness to palpation of the paravertebral muscles, tight muscle band and trigger point (a twitch response was obtained along with radiating pain on palpation); FABER test is positive. The patient is diagnosed with pain in joint of pelvic region and thigh and chronic pain syndrome. Primary Treating Physician Review of Outside Records dated 11/01/2013 states a request is denied for a right L4-L5 radiofrequency ablation. The patient is getting worse, not better. She is falling as the low back pain limits her ability to compensate for the loose ends subluxing hip. Pre-initial RFA visit note dated 02/20/2013 notes the patient with 6/10 pain. Visit note (one month post RFA) dated 04/11/2013 states her main pain is in the right lateral leg and thigh ranging 5-7/10. Visit note (2 months post RFA) dated 05/02/2013 reported no VAS.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT L4-L4 RADIOFREQUENCY ABLATION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

**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, Facet joint radiofrequency neurotomy.

**Decision rationale:** According to the ODG - Criteria for use of facet joint radiofrequency neurotomy include the following: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. (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 ≥ 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). (3) 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.(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. According to the Official Disability Guidelines, Facet joint radiofrequency neurotomy is a under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis (only 3 RCTs with one suggesting pain benefit without functional gains, potential benefit if used to reduce narcotics). Studies have not demonstrated improved function. The medical records do not document subjective complaints and objective findings consistent with facet-mediated pain. In addition, the medical records do not establish the patient obtained at least 50% pain reduction for at least 3 months, and sustained pain relief of at least 6 months duration following the prior RFA procedure. In the progress note on date of service 9/13/13, there is mention of 80% benefit from the RFA, but no duration of pain relief is mentioned. Another follow-up note on 10/11/2013 fails to document any duration of pain reduction following the radiofrequency procedure. In addition, there is no evidence of a formal plan of additional evidence-based conservative care. Furthermore, the medical records do not establish other pain generators have been addressed. The medical necessity of repeat RFA has not been established.