

<b>Case Number:</b>	CM13-0060423		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	09/13/2010
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2013

### 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 Physical Medicine and Rehabilitation, 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:

This 48 year-old male patient sustained an injury when his chair collapsed and he fell onto his left buttock and lower back on 9/13/10 while employed by [REDACTED]. An MRI of the lumbar spine on 11/16/10 showed L5-S1 spondylosis with spondylolisthesis, 2mm anterolisthesis, and moderate degenerative changes with moderate bilateral foraminal narrowing/stenosis impinging on L5 nerve without disc herniation. Conservative care has included medications (OxyContin, vicodin, meloxicam), physical therapy, at least 7 acupuncture sessions, and lumbar epidural steroid injections without relief. Diagnoses include chronic lumbar strain, bilateral lumbar facet arthropathy, and reactive depression. Per report, the patient underwent L4-5 and L5-S1 facet joint denervation by radiofrequency neurotomy on 8/31/11 reported as successful providing significant decrease on left side low back pain. The patient had repeat radiofrequency ablation on 12/7/11 which lasted 15-16 months. The report dated 11/12/13 from the provider noted that the patient was with low back pain rated at 8/10 with difficulty walking and sitting. He was working full duty, but reported depression. Pain radiates to the left buttock, the left superior posterior thigh, and around the waist. There was tenderness on palpation of lumbar paraspinals at L3-5 with extension to 10 degrees limited by pain, and lateral tilt to left 15 and right 20 degrees. Lumbar facet loading increased lower back pain. Treatment included left L4-5 and L5-S1 diagnostic facet block radiofrequency ablation under fluoroscopy and IV sedation, psych consult, and urine toxicology screening.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LEFT PERMANENT LUMBAR FACET INJECTION (AKA RADIO FREQUENCY ABLATION): Upheld**

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

**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, pages 420-422

**Decision rationale:** Per the guidelines, facet joint radiofrequency neurotomy/ablation has conflicting evidence of efficacy and is considered under study without clear benefit or functional improvement. Criteria include documented failed conservative treatment trial without evidence of radicular findings not met here with continued radiating low back pain and MRI findings of neural foraminal stenosis without clear facet arthropathy. Submitted reports have not demonstrated objective clinical findings of pain relief in terms of reduction in opioid prescription dosage and medical utilization, or an increase in activities of daily living and function for greater than 50% sustained for at least 6 months duration. The request is not medically necessary and appropriate.

**FLUOROSCOPIC GUIDANCE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**IV SEDATION BODY PART: LUMBAR SPINE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.