

Case Number:	CM13-0072685		
Date Assigned:	01/17/2014	Date of Injury:	10/14/2011
Decision Date:	06/06/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	12/31/2013

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, has a subspecialty in Pain Management 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 an employee of [REDACTED] and has submitted a claim for low back pain associated with an industrial injury date of October 14, 2011. Treatment to date has included medications, TENS unit, physical therapy, acupuncture, chiropractic care, and bilateral L4-L5 and L5-S1 facet joint injections on 10/16/2013. Medical records from 2011 through 2014 were reviewed, which showed that the patient complained of low back pain, 6/10, radiating to the posterior neck and lumbosacral region, and characterized as sharp, burning, and throbbing. Pain is made worse by prolonged sitting and is relieved by hot baths. The patient also complained of numbness and tingling on her left foot; which radiated to the left posterior thigh and calf. On physical examination, thoracolumbar posture was preserved and gait was normal. There was tenderness of the bilateral lumbar paraspinals and gluteals. Range of motion was limited. Straight leg raise test was positive on the left. There were no sensorimotor deficits of the lower extremities. An MRI of the lumbar spine dated 01/18/13 revealed right posterolateral synovial cyst extending from the right L5-S1 facet joint; thickening of ligamentum flavum at multiple levels; and minimal broad-based disc bulges seen at L3-4 and L4-5 without any spinal canal stenosis or nerve root impingement. Utilization review from December 11, 2013 denied the request for Lumbar medial branch RFA because the request did not specify laterality and there was no demonstration of a successful response to previous facet joint injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

INJECTION: LUMBAR MEDIAL BRANCH RFA: Upheld

Claims Administrator 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 Chapter.

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 Section.

Decision rationale: According to ACOEM Practice Guidelines, good quality medical literature does not exist regarding radiofrequency neurotomy of facet joint nerves in the lumbar spine and that lumbar facet neurotomies reportedly produce mixed results. In addition, facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The ODG Low Back Section states the criteria for facet joint radiofrequency neurotomy should include a diagnosis of facet joint pain using a medial branch block, and that no more than two joint levels are to be performed at one time. In this case, the patient underwent bilateral L4/L5, and L5/S1 facet joint injections demonstrating intraarticular flow as cited in the operative report, dated 10/16/2013. An appeal letter, written 01/07/2014, stated that RFA is recommended to effectively anesthetize because the previous intra-articular facet injection was not sufficient. The intended levels for medial branch block injection were L3/L4/L5 bilaterally, as stated in the appeal letter. However, this exceeds the guideline recommendation of no more than two joint levels as stated in the guidelines above. Moreover, the present written request does not clearly indicate the site to be subjected to neurotomy, as well as the laterality. The request is incomplete; therefore, the request for injection: lumbar medial branch RFA is not medically necessary.