

<b>Case Number:</b>	CM14-0133970		
<b>Date Assigned:</b>	08/25/2014	<b>Date of Injury:</b>	11/18/2004
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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:

This 52-year-old male sustained an industrial injury on 11/18/04. The mechanism of injury was not documented. Past surgical history was positive for L2-3 lumbar laminotomy and discectomy and disc replacement arthroplasty at L4-5 and L5-S1. Records indicated the patient had previously undergone a series of facet rhizotomies but date and response were not documented. The patient underwent an L3/4 epidural steroid injection on 4/12/13 with excellent pain reduction and was able to stop all medications. Records indicated that the patient did very well until September 2013 when he experienced a symptom flare that was reasonably well-controlled with anti-inflammatory and pain medications. Records indicated that the patient experienced a flare of right sided back pain radiating into the right thigh in April. There was limited flexion but normal neurologic examination. The patient was placed on a course of oral steroids with temporary benefit. The 7/23/14 treating physician report cited increased pain over the last two weeks with numbness on the outer three toes of the left foot. Physical exam documented satisfactory sensory, motor, and deep tendon reflexes. The treatment plan recommended a non-steroidal anti-inflammatory drug and proton pump inhibitor. Follow-up was recommended in 2 months. An 8/5/14 DWC request for left L3, L4, and L5 rhizotomy was submitted. The 8/7/14 utilization review denied the request for left L3, L4, and L5 rhizotomies based on failure to meet guideline criteria.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L3 Rhizotomy:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 196. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Facet joint radiofrequency neurotomy.

**Decision rationale:** The California ACOEM Revised Low Back guidelines state that radiofrequency neurotomy, neurotomy, and facet rhizotomy are not recommended for the treatment of any spinal condition. The Official Disability Guidelines indicate that facet joint radiofrequency neurotomy is under study. Criteria state that 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). 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. Guidelines do not recommend that more than two joint levels be performed at one time. Guideline criteria have not been met. The request for exceeds guideline recommendations. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. There is no documentation of prior rhizotomy response consistent with guideline criteria. Therefore, this request is not medically necessary.

**Left L4 Rhizotomy:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 196. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Facet joint radiofrequency neurotomy.

**Decision rationale:** The California ACOEM Revised Low Back guidelines state that radiofrequency neurotomy, neurotomy, and facet rhizotomy are not recommended for the treatment of any spinal condition. The Official Disability Guidelines indicate that facet joint radiofrequency neurotomy is under study. Criteria state that 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). 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. Guidelines do not recommend that more than two joint levels be performed at one time. Guideline criteria have not been met. The request for exceeds guideline recommendations. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative

treatment had been tried and failed. There is no documentation of prior rhizotomy response consistent with guideline criteria. Therefore, this request is not medically necessary.

**Left L5 Rhizotomy: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 196. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Facet joint radiofrequency neurotomy.

**Decision rationale:** The California ACOEM Revised Low Back guidelines state that radiofrequency neurotomy, neurotomy, and facet rhizotomy are not recommended for the treatment of any spinal condition. The Official Disability Guidelines indicate that facet joint radiofrequency neurotomy is under study. Criteria state that 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). 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. Guidelines do not recommend that more than two joint levels be performed at one time. Guideline criteria have not been met. The request for exceeds guideline recommendations. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. There is no documentation of prior rhizotomy response consistent with guideline criteria. Therefore, this request is not medically necessary.

**Sedation during rhizotomy procedures: 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.

**Fluoroscopic guidance during rhizotomy procedures: 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.