

Case Number:	CM14-0156112		
Date Assigned:	09/25/2014	Date of Injury:	08/26/2009
Decision Date:	12/04/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/23/2014

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 Anesthesiology, and is licensed to practice in Tennessee, North Carolina & Georgia. 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 injured worker is a 50 year old male who reported injury on 08/26/2009. The mechanism of injury was not provided. The injured worker's diagnoses included status post head trauma 1999 with chronic left hemiparesis, spastic gait, equines deformity, and foot drop; left knee internal derangement; status post left knee arthroscopy in 06/2010; and bilateral lower lumbar facet arthropathy. The injured worker's past treatments included medications and surgery. The injured worker's diagnostic testing was not included. The injured worker's surgical history included left knee arthroscopy in 06/2010 and bilateral L3-S1 facet rhizotomies on 01/20/2014. On the clinical note dated 08/25/2014, the injured worker complained of sharp increase in pain in his low back. The medical records indicate lumbar rhizotomy on 01/20/2014 provided greater than 6 months of pain relief of up to 60% improvement, with increased activities of daily living. The injured worker had left hemiparesis in the form of contracture and hemiplegia, gait remains spastic with left foot equines deformity, moderate pain over the lower lumbar facets L4-5 and L5-S1, and bilaterally painful facet loading. The injured worker's medications included Norco, muscle relaxer, anti-inflammatory, and topical patch. The request was for lumbar facet rhizotomy at bilateral L4-5 and L5-S1. Section 10: The request for lumbar facet rhizotomy at bilateral L4-5 and L5-S1 is not medically necessary. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar facet rhizotomy at Bilateral L4-L5 and L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Facet Joint Injections

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet joint radiofrequency neurotomy.

Decision rationale: The request for Lumbar facet rhizotomy at Bilateral L4-L5 and L5-S1 is not medically necessary. The Official Disability Guidelines state 1 set of diagnostic medial branch blocks is required with a response of greater than 70% with pain response lasting at least 2 hours for Lidocaine. Guidelines recommended it be limited to patients with low back pain that is nonradicular and at no more than 2 levels bilaterally. There must be documentation of failure of conservative treatment including home exercise, PT, and NSAIDs prior to the procedure for at least 4 to 6 weeks. No more than 2 facet joint levels are to be injected in 1 session. The injured worker has recurrent low back pain. The clinical records indicate a previous L5-S1 facet rhizotomy on 01/20/2014 that provided 60% improvement for greater than 6 months. Physical examination indicated left hemiparesis in the form of contracture and hemiplegia, gait remained spastic with left foot equines deformity, moderate pain over the lower lumbar facets at L4-5 and L5-S1, facet loading caused pain bilaterally, and muscle rigidity noted throughout. However, there is a lack of documentation indicating failure of conservative treatment including home exercise, PT, and NSAIDs for at least 4 to 6 weeks prior to the procedure. There is a lack of documentation indicating the previous rhizotomy to have provided at least 70% improvement, the previous rhizotomy provided was noted to provide 60% improvement for greater than 6 months. As such, the request for lumbar facet rhizotomy at bilateral L4-5 and L5-S1 is not medically necessary.