

Case Number:	CM14-0189328		
Date Assigned:	11/20/2014	Date of Injury:	01/16/2013
Decision Date:	01/08/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/13/2014

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 Spine 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 injured worker is a 52-year-old male who reported an injury on 01/16/2013 due to an unknown mechanism. Diagnoses were lumbar strain with facet hypertrophy, L4-5 and L5-S1 intervertebral annular bulging, mild, L4-5 and L5-S1 facet arthrosis, right L5-S1 subarticular narrowing with mild focal impingement of the exiting right L5 nerve root, mild, right lower extremity neuralgia pain related to lumbosacral facet focal compression, opiate induced constipation, type II diabetes mellitus, and pain induced depression. Past treatments were radiofrequency rhizotomy at the L4-5 and L5-S1 on 09/11/2014, medications, physical therapy, aqua therapy, and home exercise program. Physical examination, dated 11/25/2014, revealed lumbar muscle spasm on the right that was reported to be moderate. Lumbar flexion was to 50 degrees, lumbar extension was to 20 degrees, right lateral bending was to 20 degrees, and left lateral bending was to 20 degrees. Supine straight leg raise on the right was to 70 degrees, the left was to 80 degrees. Tenderness was noted at the L5-S1 on the left, reported as mild, on the right was reported as moderate. Sacroiliac joint on the left was mild, and on the right, was mild. Lower extremity muscle testing was 5/5. Sensitivity to the lower extremities was 5/5. Treatment plan was to continue medications as prescribed. The rationale was not submitted. The Request for Authorization was submitted and dated 10/08/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radio frequency rhizotomy at S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet Joint Radiofrequency Neurotomy

Decision rationale: The decision for radio frequency rhizotomy at S1 is not medically necessary. The California MTUS/ACOEM states there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The Official Disability Guidelines further state facet radiofrequency neurotomy is recommended as a treatment that requires a diagnosis of facet joint pain using a medial branch. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at greater than 50% relief that is sustained for at least 6 months. 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. No more than 2 joint levels are to be performed at 1 time. If different regions require neural blockade, these should be performed at intervals of no sooner than 1 week, and preferably 2 weeks for most blocks. There should be evidence of a formal plan of additional evidence based conservative care in addition to facet joint therapy. The requesting physician did not include adequate documentation of significant physical exam findings congruent with facetogenic pain. The clinical documentation submitted for review does not provide evidence that the injured worker had a duration of pain relief for 12 weeks at greater than 50% relief sustained for at least 6 months. There was no indication that the injured worker had a decrease in medications. There was no evidence of a formal plan of additional evidence based conservative care in addition to the radiofrequency rhizotomy at S1 level. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, the request is not medically necessary.

Bilateral medial facet branch blocks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet Joint Diagnostic Blocks (injections)

Decision rationale: The decision for bilateral medial facet branch blocks is not medically necessary. The California ACOEM Guidelines state invasive techniques, such as facet joint injections, are of questionable merit. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit for injured workers presenting in the transitional phase between acute and chronic pain. As ACOEM does

not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings, although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDs prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. Additionally, 1 set of diagnostic medial branch blocks is required with a response of 70%, and it limited to no more than 2 levels bilaterally and they recommend no more than 1 set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered under study). The injured worker had medial branch blocks prior to this request, with no results indicated in the clinical documentation submitted for review. The efficacies of the prior medial branch blocks were not reported. Therefore, this request is not medically necessary.