

<b>Case Number:</b>	CM14-0198797		
<b>Date Assigned:</b>	12/09/2014	<b>Date of Injury:</b>	04/22/2011
<b>Decision Date:</b>	01/21/2015	<b>UR Denial Date:</b>	11/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2014

### 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 New York. 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 (IW) is a 55-year old with a 04/22/2011 date of injury. Results of the work injury include posterior lumbar pain with both left and right sided lumbar pain. Subjectively the IW has stiff and guarded movements with limited mobility. On exam there is tenderness in the left lumbar paraspinal area, moderate tenderness in the right lumbar paraspinal area, moderate tenderness of the left SI (sacroiliac) joint, and moderate tenderness of the right SI joint. There is no kyphosis, lordosis, or scoliosis. The IW had full painless range of motion of the thoracic and lumbar spine with normal stability, normal strength and tone. Range of motion is normal in the major joints. The low back is restricted in extension. Faber, Patrick, and straight leg raising are normal or negative and deep tendon reflexes are normal and symmetrical. The IW is an established patient of the treating physician, and his medical records were reviewed but no history of present illness or past medical history is included in the medical record submitted. Medications taken include Lexapro 20 mg, Nucynta ER 150 mg, and Nucynta 50 mg as needed for breakthrough pain. The IW relates an improvement in function due to an increased effectiveness of medication after bilateral L4-L5 and L5-S1 denervation in 07/24/2014. The plan of care was for a repeat facet denervation. Approval for a repeat lumbar facet denervation at bilateral L4-5 and L5-S1 was requested on the request for authorization application (ROA) submitted 11/04/2014. This ROA does not accompany the submitted medical records. The Utilization Review agency reviewed records, procedure reports and MRI of the lumbar spine and issued a letter of non- recommendation for certification of the request for a repeat facet denervation on 11/11/2014. ACOEM (American College of Occupational and Environmental Medicine) guidelines table 8-8 and pages 300-301, ASIPP (American Society of Interventional Pain Physicians) practice guidelines, and ODG-TWP (Official Disability Guidelines Treatment in Workers Compensation) treatment guidelines were cited. The repeat lumbar facet denervation

at bilateral L4-5 and L5-S1 was determined to not be medically necessary based on these guidelines. There also was noted a lack of documentation of reduction in medications or improved function. It was noted that the effect of prior nerve destruction did not last three months. Guidelines do not support a repeat procedure prior to 6 months. A request for an independent review of the denial of repeat lumbar facet denervation at bilateral L4-5 and L5-S1 was submitted by the IW on 11/25/2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Repeat lumbar facet denervation at bilateral L4-L5 and L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300 - 301.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ODG low back chapter

**Decision rationale:** The ODG guidelines indicate that functional proven and pain reduction must be established after previous facet injections. Established criteria for repeat facet injections have not been met in this case. Specifically there is not documented functional improvement and reduction pain medication from previous facet injections. Therefore, repeat facet injections not medically necessary.