Case Number:	CM14-0202672		
Date Assigned:	12/15/2014	**Date of Injury:**	07/23/2012
Decision Date:	02/09/2015	**UR Denial Date:**	11/25/2014
Priority:	Standard	**Application Received:**	12/04/2014

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 Emergency Medicine and is licensed to practice in Minnesota. 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 41 year old male sustained a work related injury on 07/23/2012. The injury occurred while operating heavy equipment when the machine bucked up and slammed down to the ground very hard causing him to bounce sharply on his seat. The injured worker subsequently complained of immediate pain in the whole spine. On 03/06/2014, the injured worker underwent bilateral L3, L4, and L5 medial branch radiofrequency neurolysis under fluoroscopy. The operative report was submitted for review. On 04/04/2014 a post procedure follow up noted that the injured worker reported over 50 percent improvement of pain following the radiofrequency neurolysis with significant relief. Pain was not 100 percent gone, but was at a much more manageable level. Current medication included Percocet three times a day as needed. According to the provider, an MRI of the lumbar spine dated 10/25/2012 revealed stable compression fractures at T12, L2 and L4. The fractures at T12 and L2 appeared subacute. The fractured L4 appeared chronic. There were degenerative disc changes L3-L4 through L5-S1 inclusive. Disease was most severe at L5-S1 and L4-L5 with contact with the left L4 exiting nerve root at L4-L5. According to an orthopedic evaluation dated 07/24/2014, the injured worker complained of constant pain in the lower back and pain radiating into the right buttocks and leg and numbness and tingling in the right leg to the foot. In regards to activities of daily living, the injured worker could lift and carry very light objects. He could walk up to one quarter mile, perform very light activity for at least two minutes, climb one flight of stairs with a lot of difficulty, sit for up to one hour, stand or walk up to one half hour at a time, reach and grasp something off of a shelf at chest level with no difficulty, push or pull light objects, grip, grasp, hold or manipulate objects with his hands with no difficulty and kneel, bend or squat with a lot of difficulty. Sleep was greatly disturbed with three to five hours of sleeplessness due to his symptoms. Pain interfered with his ability to travel some of the time, engage in social activities some to most of the time or

recreational activities all of the time. The provider's impression included status post laminectomy L5-S1 in 2000 by patient history and compression fractures T12, L2, L4 by MRI; chronic low back pain with radicular pain. It was the provider's opinion that the injured worker was at a permanent and stationary level. On 11/25/2014, Utilization Review non-certified lumbar radiofrequency ablation that was requested on 11/18/2014. According to the Utilization Review physician, the provider noted in the chart that the injured worker had low back surgery. The type of surgery and the levels were not discussed. The Official Disability Guidelines do not recommend injections at the surgical levels. The provider also noted that the injured worker had good results in the past with the facet radiofrequency. Pain and functional improvement were not documented at that time. The injured worker continues to have radicular pain and pain with facet loading. However, the levels were not specified. Conservative care in addition to facet joint therapy was not recommended. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar radiofrequency ablation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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) Section: Low back, Topic: Facet joint radiofrequency neurotomy, facet joint medial branch blocks, facet joint diagnostic blocks.

Decision rationale: California MTUS guidelines indicate facet rhizotomy provides good temporary relief of pain in the cervical spine. However, similar quality literature does not exist for the procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. ODG guidelines indicate one set of diagnostic medial branch blocks is required with a response of greater than 70%. The pain response should last at least 2 hours for lidocaine. It is limited to patients with low back pain that is nonradicular and at no more than 2 levels bilaterally. There is documentation of failure of conservative treatment including home exercise, PT and NSAIDs prior to the procedure for at least 4-6 weeks. No more than to facet joint levels are injected in one session. Recommended volume of no more than 0.5 cc of injectate is given to each joint. No pain medication from home should be taken at least 4 hours prior to the diagnostic block and 4-6 hours afterwards. Opioids should not be given as a sedative during the procedure. The use of IV sedation may be grounds to negate the results of diagnostic block and should only be given in cases of extreme anxiety. The patient should document pain relief with an instrument such as a VA S scale emphasizing the importance of recording the maximum pain relief in maximum duration of pain. Patient should also keep medication use and activity logs to support subjective reports of better pain control. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. ODG guidelines for radiofrequency neurotomies are used.An MRI scan of the

lumbar spine dated October 25, 2012 showed stable compression fractures at T12, L2, and L4 with degenerative disc changes from L3-4 through L5-S1, most severe at L4-5 and L5-S1 levels with contact with the left L4 exiting nerve root at L4-5 and contact with the transitioning right S1 nerve root at L5-S1. The L4 compression fracture appeared chronic and the T12 and L2 appeared subacute. On March 6, 2014 he underwent bilateral L3, L4, and L5 medial branch radiofrequency neurotomies under fluoroscopy. The procedure helped for 30 days and pain recurred. The guidelines indicate that not more than 2 levels should be done at one time and the procedure should not be repeated if the relief does not last 3 months at 50%. Documentation indicates that he has right-sided radicular pain and also some radicular pain on the left side at times. The procedure should not be performed in the presence of radicular pain. There is no evidence of a formal plan of additional conservative care in addition to the facet joint therapy. Based upon the above, the guideline criteria have not been met and as such, the medical necessity of the request for lumbar radiofrequency ablation is not substantiated.