

Case Number:	CM15-0130627		
Date Assigned:	07/17/2015	Date of Injury:	01/21/2004
Decision Date:	08/13/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	07/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 77-year-old male who sustained an industrial injury on 1/21/04. Injury occurred while he was assisting to move a pipe weighing an approximate 250 pounds. Past medical history was positive for insulin dependent diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. The 5/24/08 bilateral lower extremity electrodiagnostic study evidenced bilateral L4 and/or L5 radiculopathy, and L5 or S1 radiculopathy on the left. The 6/14/08 lumbar spine MRI documented marked facet arthropathy at L3/4 and L4/5. The 9/24/13 lumbar spine MRI demonstrated multilevel posterior disc bulges, with mild canal stenosis greatest at T11/12, and mild to moderate foraminal stenosis. He underwent bilateral L3/4 and L4/5 rhizotomy on 11/7/13 following successful medial branch blocks. Records documented improvement in pain reported following the rhizotomy procedure of 60% in February and March 2014, 30-40% in September 2014, and an overall improvement of 80% was reported on 1/12/15. There was no change noted in objective findings. The 3/27/15 and 4/21/15 treating physician reports cited significant pain reduction with 75% relief for about a year following rhizotomy. The 5/5/15 treating physician report cited complaints of grade 7/10 aching lower back pain radiating into the bilateral lower extremities with numbness and tingling, left slightly worse than the right. Standing, walking, and sitting from a standing position caused an increase in pain. He used a single point cane and wheelchair. Pain was worse with leaning back. He reported difficulty walking for any length of time. He required assistance to rise from a seated position. Physical exam documented restricted range of motion, decreased bilateral L4, L5, and S1 dermatomal sensation, 1+ and symmetrical lower extremity deep tendon reflexes, negative

straight leg raise, and positive facet challenge to the lumbar spine. Motor testing documented global lower extremity weakness, most significant in left extensor hallucis longus and bilateral ankle plantar flexion. The diagnosis included lumbar spondylosis, lumbar facet arthropathy, and lumbar degenerative disc disease. The treatment plan requested a repeat rhizotomy at L3/4 and L4/5. The injured worker had a rhizotomy at L3/4 and L4/5 on 11/7/13 that provided 75% relief for approximately one year. He had positive physical exam findings supporting a repeat injection. A repeat EMG/nerve conduction study of the bilateral lower extremity was recommended. Authorization was requested for L3/4 and L4/5 rhizotomy. The 5/12/15 treating physician report indicated that conservative treatment included medication management and a home exercise program. The 6/5/15 utilization review non-certified the request for L3/4 and L4/5 rhizotomy as there was no documentation of a formal plan of conservative care to be provided with the procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-4 and L4-5 rhizotomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic (Acute & Chronic): Facet joint radiofrequency neurotomy (2015).

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) Low Back Lumbar & Thoracic, Facet joint radiofrequency neurotomy.

Decision rationale: The California MTUS guidelines state that facet neurotomies are under study and should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The Official Disability Guidelines 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). No more than 3 procedures should be performed in a year's period. 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. There should be evidence of a formal plan of additional evidenced based conservative care in addition to facet joint therapy. Guideline criteria have not been met. This injured worker presents with imaging findings of marked facet arthropathy at the L3/4 and L4/5 levels with chronic function-limiting low back pain. Physical exam findings are reported consistent with facet pathology and radiculopathy. Electrical studies are consistent with radiculopathy. Response to prior radiofrequency ablation has been reported in excess of guideline requirements for at least 6 months. Records do not clearly delineate benefit achieved relative to VAS score, decreased medications, and improvement in function. The treating physician has reported a home exercise program. Given the available records, overall benefit has not been documented and does not meet guidelines criteria. In addition, this request is not supported in this clinical radicular setting. Therefore, this request is not medically necessary.