

<b>Case Number:</b>	CM15-0137730		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	10/13/2008
<b>Decision Date:</b>	08/25/2015	<b>UR Denial Date:</b>	07/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/16/2015

### 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 67-year-old female who sustained an industrial injury on 10/13/08. The mechanism of injury was not documented. The 9/2/14 treating physician report indicated that the injured worker had 80% relief after her lumbar radiofrequency rhizotomy in August 2014. She reported lumbar pain had reduced to grade 4/10 following the procedure. There was no specific documentation of improvement in function or reduction in medication use. The 10/29/14 treating physician report documented complaints that her back was in pain. She had undergone a radiofrequency rhizotomy in August but stated it was still bad. Without pain medications, the pain was 9/10 and with medications, the pain was 8/10. The 1/28/15 treating physician report cited continued lumbar pain and spasms, with aching pain from the right hip to ankle. She reported grade 9/10 pain without medications and 8/10 with medications. The 2/25/15 treating physician report cited progressively worsening low back pain radiating down both legs to the ankles. The 4/28/15 lumbar spine MRI impression documented an L2/3 disc bulge with posterior element hypertrophy creating mild central canal and bilateral recess stenosis. There was L3/4, L4/5 and L5/S1 anterolisthesis without pars interarticularis defects. There were significant hypertrophic changes noted in the facet joint and ligamentum flavum bilaterally. The 6/25/15 treating physician report cited a history of neck and lower back pain in the setting of facet osteoarthritis. She reported the epidural on 5/12/15 had relieved her leg pain by 65%. She had residual low back pain that prevented her from prolonged standing and a decreased ability to participate in her twice-daily 20-minute walks. She had to stop frequently to bend forward to relieve her lower back pain. She reported a burning sensation down her right leg. Medications

reduced her pain from 8/10 to 4/10. She reported a 50% relief in her lumbar pain following her radiofrequency rhizotomy in August 2014 that lasted for 6 months with a slow return of symptoms. She would like to repeat the radiofrequency rhizotomy so she can wean her Percocet. Physical exam documented severe lumbar pain with extension, negative straight leg raise, negative Patrick's, flexion restricted by 10%, lateral bending restricted by 70%, and severe tightness, pain and spasms. Deep tendon reflexes were +1 and symmetrical. The treatment plan recommended bilateral L4-5 and L5-S1 radiofrequency rhizotomy with the goal of weaning Percocet after it provides pain relief. Authorization was requested for bilateral L4-5 and L5-S1 radiofrequency rhizotomy. The 7/2/15 utilization review non-certified the request for bilateral L4/5 and L5/S1 radiofrequency rhizotomy as there was no evidence of decreased use of medications and there was no indication of functional improvement following the radiofrequency ablation in August 2014.

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

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

#### **Bilateral L4-5 and L5-S1 Radiofrequency Rhizotomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & chronic).

**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 diagnostic blocks (injections); 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 indicate that facet joint radiofrequency ablation (neurotomy, rhizotomy) is under study. Criteria 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. The ODG do not recommended facet joint diagnostic blocks for patients with radicular low back pain. Guideline criteria have not been met. This injured worker presents with low back pain with a burning sensation down the right leg. An epidural steroid injection was performed on 5/12/15 with 65% relief of leg pain. Prior lumbar radiofrequency rhizotomy had been performed in August 2014. The response was documented as almost 50% relief for almost 6 months but the serial progress reports do not reflect this in detail. The injured worker reported a return of grade 9/10 pain as early as October with no specific documentation of functional improvement or medication reduction. Additionally, this injured worker has radicular symptoms, which is an exclusionary criteria. Therefore, this request is not medically necessary.