

<b>Case Number:</b>	CM15-0023041		
<b>Date Assigned:</b>	04/20/2015	<b>Date of Injury:</b>	06/13/2014
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	01/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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: California, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 65-year-old male, who sustained an industrial injury on June 13, 2014. The injured worker has been treated for left forearm, left wrist, back and right-sided facial complaints. The diagnoses have included lumbosacral facet arthropathy, myofascial pain syndrome, cervical facet arthropathy, occipital neuralgia, lumbosacral radiculitis, facial contusions, cervical strain, left wrist/forearm contusions, headaches and trochanteric bursitis. Treatment to date has included medications, radiological studies, medial branch blocks, physical therapy and a left carpal tunnel release. Current documentation dated January 16, 2015 notes that the injured worker reported low back pain radiating to the buttocks and back of both thighs. He also noted left neck pain with radiation to the left shoulder and between the shoulder blades, right shoulder pain and upper neck pain with associated headaches. Physical examination of the cervical and thoracic spine revealed no tenderness and a full range of motion. Lumbar spine examination revealed loss of lordosis, tenderness to palpation, trigger points on both sides and a decreased range of motion. Lumbar facet loading and a straight leg raise test were positive bilaterally. A prior lumbar medial branch block was noted to be effective for four hours with fifty percent pain relief. The pain gradually returned to the baseline level. The treating physician's plan of care included a request for a radiofrequency ablation of the lumbar medial branch nerves.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Radiofrequency Ablation of the Lumbar Medial Branch Nerves: 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 (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation ODG Low Back, Facet Joint Radiofrequency Neurotomy.

**Decision rationale:** Per MTUS ACOEM, "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. Per ODG with regard to facet joint radiofrequency neurotomy: "Under study. Conflicting evidence, which is primarily observational, is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Studies have not demonstrated improved function." The ODG indicates that criteria for facet joint radiofrequency neurotomy are as follows: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections). (2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A 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. (3) 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. (4) No more than two joint levels are to be performed at one time. (5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. (6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. Per the documentation submitted for review, it was noted that the injured worker had a medial branch block at L4-L5 and L5-S1 11/2014 bilaterally which resulted in 5-% pain decrease over 4 hours. Per the ODG guidelines, diagnostic blocks require a 70% response to support radiofrequency ablation. As the criteria was not met, the request is not medically necessary.