

<b>Case Number:</b>	CM15-0219208		
<b>Date Assigned:</b>	11/12/2015	<b>Date of Injury:</b>	04/17/2013
<b>Decision Date:</b>	12/23/2015	<b>UR Denial Date:</b>	10/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2015

### 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: 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 53-year-old male who sustained an industrial-work injury on 4/17/13. Injury occurred when he was lifting a garage door and felt a pop in his back with onset of pain. The 1/23/15 lumbar spine MRI impression documented progression of multifactorial changes at L4/5 with a 7 mm central disc protrusion with moderate central canal stenosis, lateral recess stenosis, and neuroforaminal stenosis. There was slight progression of multifactorial changes at L3/4 with right lateral recess stenosis, neuroforaminal stenosis, and contact with the right exiting L3 nerve root. The 8/10/1 lumbar spine x-ray impression documented multilevel degenerative disc disease associated with facet arthropathy at L4/5 and minimal retrolisthesis at L4/5. There was no evidence of instability. The 8/10/15 neurosurgical report documented a history of lower back pain radiating in the right leg and bilateral foot numbness. Pain was reported grade 9/10, worsening by prolonged walking, standing, and sitting. Conservative treatment had included physical therapy with traction, narcotic pain relievers, muscle relaxants, and medial branch blocks. Medial branch blocks at L3/4, L4/5, and L5/S1 provided 20% relief with the first injection and minimal relief with the next 3 injections. Imaging showed a paracentral disc herniation at L4/5 producing spinal stenosis and right greater than left lateral recess stenosis, and disc desiccation. Physical exam documented 5/5 strength in bilateral upper and lower extremities, steady gait, and pain on right hip flexion and knee extension initially limiting motion. Heel and toe walking was performed with some difficulty due to pain, right greater than left. Sensation and deep tendon reflexes were intact. The neurosurgeon opined that the majority of his lower back pain was related to his significant facet hypertrophy and

inflammatory changes and the leg pain was likely attributable to the disc herniation and lateral recess stenosis. Surgery was recommended to include right L4/5 microdiscectomy. The 9/15/15 pain management report cited increasing low back pain, more intensified in the mid back region. Pain increased with daily activity, walking, sitting, bending, stooping, and most any movements. He was unable to sleep throughout the nights due to his pain. Conservative treatment included physical therapy, massage therapy, chiropractic treatment, home exercise, and anti-inflammatory medications. Physical exam documented focal non-radicular lumbar pain, lumbar range of motion limited by pain, positive facet tenderness at L4/5 and L5/S1, and positive lumbar facet loading. Neurologic exam documented normal motor strength and reflexes. Imaging was reviewed. The diagnosis included on-going focal back pain and lumbar spondylosis without myelopathy. Gabapentin 300 mg #90 was dispensed. The treatment plan recommended bilateral L4/5 and L5/S1 radiofrequency ablation and documented agreement with the recommendation for foraminotomy at L4/5. The 9/21/15 treating physician report indicated that the injured worker was interested in moving forward with the recommended L4/5 microdiscectomy. Radiofrequency ablation was also recommended to address the pain associated with facet arthropathy. Authorization was requested for an L4/5 microdiscectomy and radiofrequency ablation of the lumbar facets right L4/5 and L5/S1 under fluoroscopic guidance followed by left L4/5 and L5/S1 radiofrequency ablation with pain management physician. The 10/6/15 utilization review certified the request for L4/5 microdiscectomy. The request for radiofrequency ablation of the lumbar facets right L4/5 and L5/S1 under fluoroscopic guidance followed by left L4/5 and L5/S1 radiofrequency ablation with pain management physician as the response to medial branch block did not meet guideline criteria.

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

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

**Radiofrequency Ablation of Lumbar Facets and Right L4-5, L5-S1 under fluoroscopic guidance followed by left L4-5, L5-S1 radiofrequency ablation under fluoroscopic guidance with pain management MD: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. 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. Treatment requires a diagnosis of facet joint pain using one set of diagnostic medial branch blocks with a response of 70%. The pain response should last at least 2 hours for Lidocaine. Guidelines do not recommended facet joint diagnostic blocks for patients with radicular low back pain or in patient in whom a surgical procedure is anticipated. Guideline criteria have not

been met. This injured worker presents with a history of low back pain radiating into the right lower extremity with bilateral foot numbness. There is imaging evidence of an L4/5 disc herniation and facet hypertrophy. There is documentation of medial branch blocks from L4-S1 with pain reduction less than guideline criteria of 70%. Additionally, the injured worker has a history of radicular low back pain and an L4/5 microdiscectomy has been requested and certified in utilization review. Therefore, this request is not medically necessary.