

Case Number:	CM15-0223585		
Date Assigned:	11/19/2015	Date of Injury:	04/01/2002
Decision Date:	12/30/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	11/13/2015

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 60-year-old female who sustained an industrial injury on 4/1/02. The mechanism of injury was not documented. Conservative treatment included activity modification, medications, physical therapy, acupuncture, chiropractic, medical branch blocks, and radiofrequency bilateral lumbar facet neurotomy. Records indicated that the injured worker had an L4/5 and L5/S1 radiofrequency neurotomy on 1/12/15. Records indicated that a 1/28/15 progress report cited grade 8/10 intractable low back pain and bilateral hip pain associated with lumbar muscle spasms and stiffness. The treatment plan recommended a lumbar epidural steroid injection. Records also documented a progress note from 5/11/15 with on-going grade 8/10 low back pain with no evidence of functional improvement relative to the radiofrequency neurotomy. The 9/26/15 treating physician report cited increasing low back pain that was stabbing, deep aching, and throbbing. Pain was rated grade 8/10 with medications. Pain was axial in nature with no radiating leg pain. Pain was exacerbated with any increased activity and prolonged standing, sitting, and walking. She was working 7 hours a day with restrictions. She had previously tried conservative treatment with physical therapy, acupuncture, and chiropractic treatment with minimal improvement. She had previously responded well with 60-80% relief of her lower back pain that last 6 months with radiofrequency neurotomy at L4/5 and L5/S1. Physical exam documented L3-L5 paralumbar spasms and tenderness, and limited lumbar range of motion in flexion, extension, and lateral rotation. Bilateral lower extremity motor and sensory exam was intact. Straight leg raise was negative bilaterally. The diagnosis was lumbar spondylosis and bilateral lumbar facet syndrome. The 9/28/15 appeal letter submitted by the

treating physician cited increased low back pain radiating across the buttocks and bilateral groin. Pain level was reported grade 8-9/10 and associated with muscle spasms and stiffness. There was no evidence of lumbar radiculopathy. Pain increased with activities and prolonged sitting, standing, or walking. Pain interfered with sleep, function, and activities of daily living. The injured worker had a significant past medical history of lumbar pain secondary to bilateral lumbar facet disease and multilevel lumbar disc bulges. The injured worker had a lumbar radiofrequency neurotomy on 1/12/15 with 50% pain relief in the low back lasting for up to 6 months and associated with increased activities of daily living and function. Authorization was requested for bilateral lumbar radiofrequency neurotomy at L4/5 and L5/S1. The 10/13/15 utilization review non-certified the request for bilateral lumbar radiofrequency neurotomy at L4/5 and L5/S1 as there was no evidence in the medical records of pain reduction, improvement in function, and reduction in medication use consistent with guideline criteria for repeat radiofrequency neurotomy. The treating physician report of benefit was not support by the progress reports.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral lumbar radiofrequency neurotomy, L4-L5, L5-S1 (sacroiliac): Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Facet joint radiofrequency neurotomy.

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. 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). 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 increased grade 8-9/10 low back pain radiating into the buttocks and groin bilaterally. Pain was worse with prolonged sitting, standing, and walking, and with any activity. There is no clinical evidence of radiculopathy. She has a significant past medical history of lumbar pain secondary to bilateral lumbar facet disease and multilevel lumbar disc bulges. Prior L4/5 and L5/S1 radiofrequency neurotomy was performed on 1/21/15. Response to this procedure was reported as 50% pain reduction to 60-80% pain reduction for up

to 6 months. However, records do not evidence this level or duration of pain reduction and there is no clear evidence of functional improvement or medication reduction. Additionally, there is no current documentation of evidence based conservative care planned in addition to facet joint therapy. Therefore, this request is not medically necessary.