

<b>Case Number:</b>	CM15-0082251		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	11/14/2001
<b>Decision Date:</b>	06/04/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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:

The injured worker is a 67-year-old male who sustained an industrial injury on 1/14/01. The mechanism of injury was not documented. Records indicated that the patient had multilevel medial branch blocks and sacroiliac joint blocks on 3/20/02. The 4/2/02 report documented on-going back pain with sciatica symptoms. The 3/10/15 treating physician report cited chronic lower back pain with intermittent right leg sciatica. Pain was mostly across the lumbosacral junction. His intermittent right leg pain seemed to have settled down. He had been using Voltaren gel, Cymbalta, and Norco. Pain level without medication was 6/10 and with medication 3/10. Physical exam documented he was able to sit comfortably, using the arm rests to stand. He walked with a slight forward flexes posture and slight limp on the left. There was lumbosacral junction tenderness to palpation. Straight leg raise elicited some mild irritability, compared to prior exams where he had a lot more irritability. The assessment was stable chronic back pain with intermittent right leg sciatica and multilevel degenerative disc space changes. Overall, his condition was about the same and he continued to have good response with medications. Follow-up was recommended in 2-3 months. The 3/25/15 pain management report cited constant low back pain radiating into the right hip. Pain was increased by yard work and decreased by minimal activity. He was previously authorized for radiofrequency ablation at L3, L4, and L5 but due to atrial fibrillation and a subsequent shingles outbreak, the procedure was not performed. He was cleared by cardiology to proceed. Lower back pain was worse with standing and walking. Back exam documented lumbar paraspinal tenderness to palpation, decreased lumbar range of motion all planes, and tenderness to palpation over the L3 to L5 facet joints on the right.

The diagnosis was lumbar intervertebral disc degeneration, sacral disorder, thoracic or lumbosacral neuritis or radiculitis, and lumbosacral spondylosis without myelopathy. Authorization was requested to provide a repeat right L3, L4, and L5 radiofrequency ablation with fluoroscopic guidance and moderate sedation. The 4/9/15 utilization review non-certified the request for L3, L4, and L5 radiofrequency ablation as the patient had well documented symptoms of radiculopathy.

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

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

**L3, L4, L5 RFA (Radiofrequency Ablation) under fluoroscopy with sedation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Facet joint radiofrequency neurotomy.

**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. 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. 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 and right lower extremity sciatica. The treating physician has documented a diagnosis of radiculopathy and positive nerve tension signs. Guidelines do not support the request in such a clinical setting. There is evidence that the patient underwent multilevel medial branch blocks in 2002 with no documentation of response or evidence of subsequent radiofrequency ablation treatment. There is no current evidence to support a diagnosis of facet-mediated pain. Therefore, this request is not medically necessary.