

<b>Case Number:</b>	CM15-0087567		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	09/11/2009
<b>Decision Date:</b>	06/19/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/06/2015

### 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:

The injured worker is a 37-year-old female who sustained an industrial injury on 9/11/09. Injury occurred relative to a slip and fall, landing on her buttocks. Past surgical history was positive for right L4 hemilaminectomy, L5/S1 lumbar microdiscectomy and nerve root exploration on 4/6/10. The 6/24/11 lumbar spine MRI impression documented a 2 mm L4/5 disc bulge without canal or foraminal stenosis, status post right hemilaminectomy with no nerve compression. There was slight facet hypertrophy at the L5/S1 level. The 8/11/11 lumbar spine CT scan impression documented scoliosis with degenerative disc disease. At L4/5, mild right neuroforaminal narrowing was suspected. At L5/S1, there was a broad-based disc bulge with mild right neuroforaminal narrowing and slight contact with the S1 nerve root. The 10/16/14 pain management report cited intractable low back pain radiating into the right lower extremity. Pain in the lower extremities was associated with stiffness, muscle spasms, weakness, and numbness and tingling sensation on the right. She reported buckling of the right leg after walking more than two blocks. The pain management physician reported a 55% pain relief for 3 months following her last epidural injection on 2/17/14. Physical exam documented bilateral facet tenderness and increased pain with extension, side bending, and rotation. Straight leg raise was positive on the right with L4-L5 myotomal weakness. The diagnosis was lumbar radiculitis, severe low back pain and lumbar degenerative disc disease. The treatment plan recommended a right transforaminal epidural steroid injection at L4/5 and L5/S1 under fluoroscopy. Records documented a right L4/5 and L5/S1 epidural steroid injection on 11/6/14. This injured worker underwent right L4/5 and L5/S1 radiofrequency neurotomy on 3/30/15 for indications of grade

5-7/10 low back, buttocks and groin pain. The 4/22/15 treating physician report of medical necessity relative to left lumbar radiofrequency neurotomy at L4/5 and L5/S1 indicated that the injured worker had grade 6-7/10 left sided low back, buttock and groin pain. Pain did not go into the lower extremities and there was no evidence of lumbar radiculopathy. She had been diagnosed with L4/5 and L5/S1 disc herniations along with bilateral lumbar facet hypertrophy. The injured worker had tried conservative treatment for over 5 months, which did not give her long-term relief. She had right sided lumbar radiofrequency neurotomy on 3/30/15 and reported 50% pain relief with significant improvement in function and activities of daily living. She took less pain medication. Physical exam documented lumbar spine tenderness L4 through S1, worse on the left, bilateral lumbar facet tenderness L3/4 to L4/5, on the left, pain with lumbar extension and side bending, fairly limited range of motion, and normal neurologic exam. The diagnosis was left lumbar facet syndrome L4/5 and L5/S1; mechanical low back pain, and no evidence of lumbar radiculopathy. The treating physician report indicated that radiofrequency neurotomy was performed in July 2014 with more than 60% pain relief lasting up to more than 6 months with significant improvement in function and activities of daily living. The 4/30/15 utilization review non-certified the request for left L4/5 and L5/S1 radiofrequency ablation as there was no evidence that opiate use decreased following radiofrequency neurotomy in July 2014 and no evidence of at least 50% improvement for 12 weeks.

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

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

#### **Left Radiofrequency Lumbar Facet L4-5 and L5-S1: 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 Chapter, Medial Branch Blocks.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 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 three 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 patient presents with low back, buttocks and groin pain that did not radiate into the lower extremities. She previously underwent radiofrequency neurotomy at L4/5 and L5/S1 in July 2014 with a report of more than 60% pain relief lasting up to more than 6 months with significant improvement in function and activities of daily living. However, records also indicate that the patient had been treated for intractable low back and right lower extremity pain with L4/5 and L5/S1 epidural steroid injections in February and November 2014. Pain reduction of 55% and significant functional improvement was also noted relative to epidural steroid injections. This does not support the reported pain relief for 6 months, based on the elevated pain levels reported in October. There is no evidence of a reduction in pain medications in 2014 or 2015. There is no evidence of a formal plan of on-going conservative treatment. Therefore, this request is not medically necessary.