Case Number:	CM14-0094983		
Date Assigned:	07/25/2014	**Date of Injury:**	10/02/2012
Decision Date:	09/19/2014	**UR Denial Date:**	06/06/2014
Priority:	Standard	**Application Received:**	06/23/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 47 year old male with an injury date of 10/02/12. Based on the 05/23/14 progress report provided by [redacted] the patient complains of chronic low back and mid back. Physical Exam: - Tenderness and tightness across lumbosacral area from T12 to L4-5 and extending to bilateral buttocks. - Pain from mid-back to right scapula- Decrease of flexion to 30% and extension to 75%. - Negative straight leg raise and negative Patrick's. Diagnoses:1. Thoracic or lumbosacral neuritis or radiculitis, unspecified2. Chronic pain syndrome3. Myalgia and myositis, unspecified4. Degeneration of thoracic or lumbar intervertebral disc5. Fracture of thoracic spine (from date of injury 10/02/12)6. Spasm of muscle7. LumbagoMRI Impressions:- Thoracic (10/19/13): mild T12 compression deformity without evidence of central spinal canal or neural foraminal compromise.- Lumbar (10/29/13): Minor disc degeneration. No significant central canal or neural foraminal compromise seenOperative Reports:- Lumbar epidural steroid injection L5-S1 (12/31/13): low back pain secondary to degenerative disc disease. Patient tolerated procedure well- Epidurogram (12/31/14): No extravasation from epidural space observed. No subarachnoid contrast observed. No evidence of blockage or epidural adhesion. Progress report dated 04/25/14 state following medications: Prilosec, Lisinopril, Norco and Ambien. It is also noted that he has been receiving authorized acupuncture treatments, which relieve some muscle tightness, but also seem to exacerbate the pain. [redacted] is requesting Bilateral Thoracic 12 - Lumbar 3 Radiofrequency Rhyzotomy. The utilization review determination being challenged is dated 06/06/14. The rationale based on ODG guidelines is that there is "no documentation that no more than two joint levels will be performed at one time". [redacted] is the requesting provider, and he provided treatment reports from 12/20/13 - 05/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Thoracic 12 - Lumbar 3 Radiofrequency Rhizotomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Diagnostic Blocks, Facet Joint Radiofrequency Neuotomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation (ODG) Lumbar spine:Recommend diagnostic blocks, as well as indicators below. Diagnostic blocks are required, with controlled comparative blocks suggested as uncontrolled blocks are associated with high false-positive rates (17% to 47% in the lumbar spine). (Bogduk, 2005) The most commonly involved lumbar joints are L4-5 and L5-S1. (Dreyfus, 2003) In the lumbar region, the majority of patients have involvement in no more than two levels. (Manchikanti, 2004) The cause of this condition is largely unknown, but suggested etiologies have included microtrauma, degenerative changes, and inflammation of the synovial capsule. There are no findings on history, physical or imaging studies that consistently aid in making this diagnosis. In 1998, Revel et al. suggested that the presence of the following were helpful in identifying patients with this condition: (1) age > 65; (2) pain relieved when supine; (3) no increase in pain with coughing, hyperextension, forward flexion, rising from flexion or extension/rotation. (Revel, 1998) This is in contrast to researchers who had previously suggested that pain secondary to the lumbar facet was increased with extension and rotation. Other authors have suggested that pain secondary to the lumbar facet is characterized by groin, buttock and/or thigh pain as well as paraspinous muscle tenderness. The condition has been described as both acute and chronic. (Resnick, 2005) See also Facet joint diagnostic blocks (injections).Suggested indicators of pain related to facet joint pathology (acknowledging the contradictory findings in current research):1) Tenderness to palpation in the paravertebral areas (over the facet region); 2) Decreased range of motion of the spine, with frequent evidence of pain on lateral bending; extension and forward flexion while standing; 3) Improvement of pain when recumbent; 4) A normal sensory examination; 5) Absence of radicular findings, although pain may radiate below the knee; 6) Normal straight leg raising unless there is hypertrophy encroaching on the neural foramen.

Decision rationale: Patient presents with low back and mid back pain. The request is for Bilateral Thoracic 12 - Lumbar 3 Radiofrequency Rhyzotomy. Patient is status post Lumbar epidural steroid injection L5-S1 based on operative report dated 12/31/13. Progress report dated 04/25/14 states that he is taking norco as one of his medications, and also receives acupuncture treatments. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12 low back complaints, pages 300-301: Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. ODG recommends on a case-by-case basis as studies have not demonstrated improved function. One RCT suggests benefit if used to reduce narcotic use. ODG "suggested indicators of pain related to facet joint pathology:(1) Tenderness to palpation in the paravertebral areas (over the facet region);(2) A normal sensory examination;(3) Absence of radicular findings, although pain may radiate below the knee;(4) Normal straight leg

raising exam."For radio frequency (RF) ablation, a positive response to diagnostic facet joint evaluation is required either by dorsal medial branch blocks with greater than 70% reduction of pain or facet joint injection. Review of the reports show that this patient presents with radicular symptoms for which facet joint work-up or injections are not recommended. Furthermore, the current request is for RF ablation without diagnostic injections. Therefore, this request is not medically necessary.