

Case Number:	CM15-0124253		
Date Assigned:	07/08/2015	Date of Injury:	09/10/2013
Decision Date:	08/05/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/29/2015

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:

This injured worker is a 64-year-old male who sustained an industrial injury on 9/10/13. Injury occurred when he was struck by the arm of a forklift in the left shoulder. The 11/23/13 lumbar spine MRI impression documented a 2-3 mm central disc protrusion at T12/L1 with disc desiccation and moderate spondylosis, disc desiccation at L1/2 and L2/3, and mild spondylosis and hypertrophic facet changes at L3/4. At L4/5, there was a 4 mm anterolisthesis of L4 to L5, severe hypertrophic facet changes, 2 mm central disc protrusion, and severe anteroposterior and lateral recess stenosis. At L5/S1, there was a 3 mm posterior disc protrusion, disc desiccation, moderate hypertrophic facet changes, and mild lateral recess stenosis bilaterally. Conservative treatment had included diagnostic bilateral L4/5 and L5/S1 lumbar facet medial nerve blocks and bilateral L4/5 and L5/S1 medial nerve radiofrequency on 8/11/14. The records indicated median branch blocks and previous radiofrequency ablation, last provided 8/11/14, as successful in relieving low back pain. Long term low back pain reduction was evidenced in the records through 4/15/15. The 5/19/15 treating physician report cited a flare-up of axial low back pain since the first week of May 2015 that had failed to resolve with his home stretching exercise program and medications. He underwent a bilateral L4/5 and L5/S1 lumbar facet radiofrequency treatment on 8/11/14 with significant long-term improvement and ability to cut down his medication. Lumbar spine exam documented mild bilateral lumbar facet tenderness at L4/5 and L5/S1, painful thoracolumbar range of motion, minimally painful toe and heel walk, and normal bilateral lower extremity neurologic exam. The impression documented possible lumbar discogenic pain, possible bilateral lumbar facet pain at L4/5 and L5/S1, right more than left, with complete back pain relief with diagnostic medial branch block, and resolved right lumbosacral radicular pain. Authorization was requested for revision bilateral lumbar facet median nerve radiofrequency at the L4/5 and L5/S1 levels between 6/3/15 and 7/18/15. The 6/4/15 utilization review non-certified the rheumatoid arthritis for revision bilateral lumbar facet median nerve

radiofrequency at the L4/5 and L5/S1 levels as there was no documentation that prior radiofrequency ablation had achieved 50% or greater pain relief or increased functionality, and there was no evidence of a formal plan of additional evidence based conservative care in addition to facet joint therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Revision Bilateral Lumbar Facet Median Nerve Radiofrequency at L4-L5 and L5-S1 levels: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar and Thoracic (Acute and Chronic), 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 ½ Lumbar & Thoracic, 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). 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. Guideline criteria have been met. This injured worker presents with a recent flare-up of axial low back pain. Clinical exam findings are consistent with imaging evidence of moderate to severe facet joint arthrosis at L4/5 and L5/S1. Records documented that prior radiofrequency treatment at the L4/5 and L5/S1 levels on 8/11/14 resulted in significant pain reduction sustained for 8 months. Although there is no specific VAS reduction documented, records do not evidence any complaints of low back pain in the post radiofrequency ablation period until the recent flare-up. There is evidence of an active home exercise program. Therefore, this request is medically necessary.