

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0144367 | | |
| Date Assigned: | 08/05/2015 | Date of Injury: | 02/24/2005 |
| Decision Date: | 12/09/2015 | UR Denial Date: | 06/25/2015 |
| Priority: | Standard | Application Received: | 07/24/2015 |

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: California, Oregon, Washington
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(n) 71 year old male, who sustained an industrial injury on 2-24-05. The injured worker was diagnosed as having chronic pain syndrome, lumbosacral spondylosis without myelopathy and post lumbar laminectomy syndrome. Subjective findings (3-17-15, 5-13-15) indicated 7 out of 10 low back pain described as constant and sharp. Objective findings (3-17-15, 5-13-15) revealed a positive straight leg raise test on the right and tenderness to palpation in the paraspinal facets. Treatment to date has included a right-sided lumbar ablation (date of service and location not provided), Roxicodone and Alprazolam. The Utilization Review dated 6-25-15, non-certified the request for a bilateral L1, L2, L3 radiofrequency ablation with fluoroscopy, sedated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L1, L2, L3.radiofrequency ablation with fluoroscopy, sedated: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Facet joint radiofrequency neurotomy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of facet joint radiofrequency neurotomy. According to the ODG, Low Back, Facet joint radiofrequency neurotomy, criteria includes a formal plan of additional evidence-based conservative care in addition to facet joint therapy. There is insufficient evidence in the records from 3-17-15, 5-13-15 demonstrating this formal plan has been contemplated or initiated. Per ODG: "Under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis (only 3 RCTs with one suggesting pain benefit without functional gains, potential benefit if used to reduce narcotics). Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints." The guidelines continue to state: Criteria for use of facet joint radiofrequency neurotomy: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections). (2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A 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. (3) 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. (4) No more than two joint levels are to be performed at one time. (5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. (6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. In this case the patient does not meet ODG criteria for facet joint radiofrequency neurotomy because no more than two joint levels are to be performed at one time. Also there is no evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. Therefore, the determination is for non-certification. Therefore, the requested treatment is not medically necessary.