

<b>Case Number:</b>	CM15-0062431		
<b>Date Assigned:</b>	04/08/2015	<b>Date of Injury:</b>	02/08/2005
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	03/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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 65-year-old male who sustained an industrial injury on 2/8/05. Injury occurred while he was pulling pallets and felt severe sharp low back pain shooting down his leg. The 9/1/05 bilateral lower extremity electrodiagnostic studies documented evidence of bilateral L5 radiculopathy. The 1/24/15 lumbar spine MRI impression documented L4/5 annular bulge with facet spurring and osteophytic ridging eccentric to the left. There was moderate left and mild to moderate right foraminal stenosis with abutment of the exiting left L4 nerve root. There was mild to moderate bilateral lateral recess stenosis with mild central canal stenosis. The 3/10/15 treating physician report cited constant severe grade 7-8/10 low back pain radiating in the mid back and occasionally shooting down the legs and both gluteal regions. Pain was increased with prolonged sitting, descending stairs, or lifting heavy objects. Physical exam documented lumbar paravertebral muscle spasms and tenderness over the L3/4, L4/5 and L5/S1 facets. There was a strongly positive hyperextension maneuver. There was restricted lumbar range of motion, positive bilateral straight leg raise, no sensory changes, and 5/5 motor strength. The diagnosis was lumbar retrolisthesis L1/2 and L2/3, disc protrusions L3/4 and L4/5, facet hypertrophy at L3/4 and L4/5, and compression of the L4 nerve root as confirmed by the updated MRI. Additional diagnoses included lumbar facet syndrome and lumbar spondylosis. The treatment plan requested bilateral L3, L4, and L5 medial branch radiofrequency lesioning and continued home exercise program. The 3/24/15 utilization review non-certified the request for bilateral L3, L4, and L5 medial branch radiofrequency lesioning as there was recent documentation of radicular symptoms, and prior records relative to the previous neurotomy

procedure were not available. Additionally, there was no conservative treatment physical therapy program recommended along with the procedure. The 4/7/15 treating physician appeal cited grade 7-9/10 lower back pain radiating to the mid-back and gluteal areas. He denied radicular symptoms. Physical exam documented decreased lumbar range of motion, positive hyperextension testing, paravertebral muscle spasms and tenderness over the lumbar facets at L3/4, L4/5, and L5/S1, increased lumbar lordosis, positive bilateral straight leg raise, 5/5 motor testing, and normal sensation. The diagnosis was unchanged from 3/10/15. The treatment plan requested appeal for bilateral L3, L4, and L5 medial branch radiofrequency lesioning.

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

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

**Bilateral L3, L4 & L5 medial branch radiofrequency lesioning:** 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), Treatment Index, 13th Edition (web), 2015, Low back - facet 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 fully met. This patient presents with constant severe lower back pain radiating into the mid back and bilateral gluteal areas. Occasional shooting pains to the legs have been noted in recent progress reports. There is imaging evidence of an L4/5 disc bulge with facet hypertrophy and neuroforaminal, lateral recess, and central canal stenosis, and abutment of the left exiting L4 nerve root. There was electrodiagnostic evidence of bilateral L5 radiculopathy. There was ongoing documentation in the records of extensor hallucis longus and plantar flexion weakness with positive straight leg raise bilaterally. There are also findings of facet joint tenderness and positive hyperextension tests. There is evidence of an independent home exercise program. Prior

radiofrequency neurotomy was reported in 2008 with 70-80% pain relief for a few years. Pain reduction was also noted with epidural steroid injections. Given the radicular symptoms documented and the lack of clear facet mediated pain based on recent MRI findings, this request is not medically necessary.