

<b>Case Number:</b>	CM15-0076863		
<b>Date Assigned:</b>	04/28/2015	<b>Date of Injury:</b>	03/01/2012
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	03/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2015

### 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: Minnesota, Florida  
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) 64-year-old female, who sustained an industrial injury on 3/1/12. She reported pain in her neck, back and both hands related to cumulative trauma. The injured worker was diagnosed as having lumbar facet arthropathy, lumbar degenerative disc disease and right sacroiliac joint dysfunction. Treatment to date has included a lumbar MRI, an epidural injection and pain medication. As of the PR2 dated 3/4/15, the injured worker reports only temporary relief from the trigger point injection that was administered to her. She still has chronic axial right sided low back pain. The treating physician noted tenderness over the lower back particularly over the facet joints at L4-L5 and L5-S1. The treating physician requested a repeat lumbar percutaneous stereotactic radiofrequency rhizotomy under C-arm fluoroscopy, right L4-5, L5-S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar percutaneous stereotactic radiofrequency rhizotomy under C-arm fluoroscopy, Right L4-5, L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation <http://www.nlm.nih.gov/pmc/articles/PMC2886243/>.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 301. Decision based on Non-MTUS Citation ODG: Section: Low Back, Topic: Radiofrequency facet neurotomy.

**Decision rationale:** California MTUS guidelines indicate although there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain, similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomy reportedly produces mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. ODG guidelines indicate that it is under study. Conflicting evidence is available as to the efficacy of this procedure. Current literature does not support that the procedure is successful without sustained relief of at least 6 months duration. Approval of repeat neurotomies dependence on many factors such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medication requirement and documented improvement in function. The medical records indicate conflicting information with regard to the efficacy of the previous blocks. On 9/25/2014 the pain level was reported to be 7/10 and increased with prolonged standing, twisting, walking, lifting, bending, stooping's squatting, and lying down on the back. Radicular pain in both lower extremities is also documented associated with positive straight leg raising indicating the presence of radiculopathy, which does not support the radiofrequency ablation. Furthermore, the guidelines require confirmation with medial branch blocks prior to a repeat radiofrequency ablation procedure and this has not been documented. The medical records do not provide evidence of improved function, significant change in the VAS score, range of motion, or decreased need for medication after the previous radiofrequency facet ablation procedure at L4-5 and L5-S1 levels on the right on 4/7/2014. As such, in light of the foregoing, the request for a repeat lumbar percutaneous stereotactic radiofrequency facet rhizotomy under C-arm fluoroscopy at L4-5 and L5-S1 level on the right is not supported and the medical necessity of the request has not been substantiated.