

Case Number:	CM13-0061325		
Date Assigned:	12/30/2013	Date of Injury:	11/03/2006
Decision Date:	05/12/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/04/2013

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 Orthopedic Surgery 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 44 year old male who was injured on 11/02/2006. He stated that he was attempting to pull a large piece of plywood from underneath another large piece of wood. He stated that he felt his back crack and the onset of low back pain. He stated that he also had neck pain at the same time. He stated that shortly thereafter he developed severe bilateral lower extremity symptoms. Diagnostic studies reviewed include x-rays of the cervical spine taken in the office on 09/15/2011 which revealed new left sided disc protrusion and uncovertebral joint hypertrophy left C5-6 level resulting in mild to moderate central canal stenosis and moderate left neural foraminal narrowing; 2) Left-sided disc protrusion and left uncovertebral joint hypertrophy at C4-5 with mild to moderate central canal stenosis and moderate left neural foraminal narrowing, stable; 3) Left-sided disc protrusion uncovertebral joint hypertrophy at C3-4 with mild central canal stenosis and mild left neural foraminal narrowing, stable; and 4) Left-sided disc protrusion at C6-7 with mild to moderate central canal stenosis, stable. PR4 dated 11/25/2013 indicated the patient had considerable physical therapy, as well as injections beginning in 2007. It should also be noted that the patient has undergone a formal course of pain management beginning April 2007. The patient presented with frequent severe neck pain that he rated at 7/10 VAS. He denied any radiation of pain or numbness into his upper extremities. He reported undergoing a medial branch block to the cervical spine in the past, which decreased his neck pain significantly for about a day. He reported low back pain rated 5/10 VAS with no lower extremity symptoms. He was taking tramadol 50 mg 4 times a day, Robaxin 750 mg as needed for spasms, and Fioricet as needed. He denied any adverse reactions to this medication regimen. He stated that the medications helped decrease his pain significantly. The patient was diagnosed with Herniated Nucleus Pulosus (HNP) of cervical spine with stenosis, Facet hypertrophy, chronic low back pain, and multilevel degenerative disc disease of the lumbar

spine. PR2 dated 10/28/2013 indicated the patient presented with neck pain, which he rated at 9/10 on a pain scale. He denied radiation of pain or numbness in his arms. He reported persistent headaches that he said continued to be severe. He stated the medication helped with his headaches significantly. He had a medial branch block of the cervical spine in the past which he says helped decrease his pain significantly for about a day. Objective findings on exam revealed range of motion of the cervical spine was decreased in all planes and limited by pain especially with extension. He had pain with facet loading in the cervical spine, left side greater than right. He had palpation tenderness in the facet region in his neck on the left side. The deltoid, biceps and wrist extensors were 5-/5 bilaterally and limited by pain. The patient was diagnosed with HNPs of the cervical spine with stenosis, and facet hypertrophy of cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

RHIZOTOMY LEFT C4-C5 & C5-C6 IS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NON-MTUS CITATION: ODG TWC 2013 NECK AND UPPER BACK: FACET JOINT PAIN SIGNS AND SYMPTOMS AND FACET JOINT RADIOFREQUENCY NEUROTOMY

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), NECK AND UPPER BACK (ACUTE AND CHRONIC), FACET JOINT RADIO FREQUENCY NEUROTOMY

Decision rationale: The Expert Reviewer's decision rationale: According to the ACOEM guidelines page 174, "there is limited evidence that radio-frequency neurotomy may be effective in relieving or reducing cervical facet joint pain among patients who had a positive response to facet injections." As per ODG, "treatment requires a diagnosis of facet joint pain. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function." In this case, this patient has undergone medial branch block to the cervical spine in the past, however, there has been very limited relief with the use of medial blocks since 2007. There is no documentation showing objective functional improvement as well as reduction in medication use from the previous medial blocks. Thus, the request does not meet the guidelines and is non-certified.