

Case Number:	CM13-0069159		
Date Assigned:	01/03/2014	Date of Injury:	06/20/2009
Decision Date:	04/21/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	12/20/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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:

This patient is a 56-year-old female with date of injury 06/20/2009. Per treating physician's report 11/09/2013, the patient presents with cervical paraspinal left greater than right side pain with a listed diagnoses of cervical spondylosis without myelopathy; degeneration of the cervical intervertebral disk; displacement of cervical intervertebral disk without myelopathy; mixed hyperlipidemia and fibromyalgia. This report indicates that the patient had prior cervical radiofrequency rhizotomy from December 2012 and continues to experience relief but beginning to experience some recurrence of pain. The patient was to be monitored for worsening pain, to consider repeat MRI and further evaluation, also considered repeat diagnostic median branch blocks for repeat RFA. The patient's current medications were Norco 5/325 #30 to be used on an as needed basis. Other medications include Cymbalta, Ambien CR, and Elavil. MRI of the C-spine from 11/28/2012 showed disk degeneration moderately at C5-C6 and C6-C7 with multilevel mild left-sided foraminal stenosis and right moderate right foraminal stenosis at C5-C6. [REDACTED] 12/28/2012 report indicates that the patient had left C5, C6, and C7 dorsal median branch diagnostic block with 50% or more reduction of pain. Prior to the procedure, pain was at 5/10 and with post procedure pain at 2/10 to 3/10. This report indicates that the patient is status post diagnostic cervical medial branch blocks for a consideration of repeat radiofrequency rhizotomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL MEDIAL BRANCH BLOCK: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: This patient presents chronic neck pain with MRI demonstrating multilevel spondylosis particularly at C5-C6 and C6-C7. The treating physician is requesting a left-sided C5, C6, and C7 dorsal median branch diagnostic blocks to consider repeat radiofrequency ablation. Review of the reports show that this patient underwent dorsal median branch radiofrequency ablation some time following December 2012. The patient underwent diagnostic dorsal medial branch blocks on 12/27/2012 at left C5 to C7. At that time, the patient's pain had improved from 5/10 to 2/10 for reported greater than 50% reduction of the pain. Some time thereafter, the patient underwent radiofrequency ablation and the treating physician reports on 11/19/2013 that the patient had significant reduction of the pain from that procedure and continue to experience reduced pain, but the pain was returning. However, review of the report show that on 05/07/2013, the treating physician discussed patient's response to the RF ablation that was recently performed. At that time, the patient's average pain was 4/10 with high pain at 6/10. He reports 50% reduction of the pain which was not as significant as before. However, just by going the pain scale that the patient is reporting, there does not appear to have been any significant change. On 12/27/2012, patient was experiencing 5/10 intensity pain. On 05/07/2013 following facet rhizotomy, the patient was still experiencing 4/10 to 6/10 pain. Furthermore, there were no changes in medication use as the patient's medications have stayed the same with Norco prescribed at #30 per month along with other adjunctive medications that have not changed. It does not appear that the patient experienced any significant reduction of pain, and no changes in use of medication. While MTUS Guidelines do not specifically discuss facet diagnostic evaluation or facet rhizotomy, The Official Disability Guidelines (ODG) Guidelines do provide specific discussion. For repeat facet rhizotomy, 50% reduction of pain lasting at least 3 months with functional benefits and medication reduction need to be documented. In this case, the treating physician has asked for dorsal medial branch diagnostic blocks in anticipation of a repeat RF ablation. There is no reason to perform diagnostic dorsal medial branches as the patient did not respond favorably to the prior facet rhizotomy. Dorsal medial branch diagnostic blocks do not need be repeated on each occasion particularly following facet rhizotomy. Repeat facet rhizotomies can be performed if 50% or more reduction of pain is documented with functional benefit including reduction of medication use. In this patient, careful review of the report show that there are really no significant improvements in the patient's visual analog pain scale and no change in use of medications. Recommendation is for denial.