

<b>Case Number:</b>	CM14-0153618		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	06/26/2007
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2014

### 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 Family Medicine and is licensed to practice in North Carolina. 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 62-year-old with a reported date of injury of 06/26/2007. The patient has the diagnoses of central disc protrusion at C4-5, C5/6 and C6/7 with bilateral facet joint arthropathy, right carpal tunnel syndrome, peripheral neuropathy, right C5 neural foraminal stenosis, cervical sprain/strain, right shoulder internal derangement, diabetes, hypertension, GERD and anxiety. Past treatment modalities have included shoulder surgery and diagnostic right C2-C3 and right C3-4 facet joint medial branch block. Per the most recent progress notes provided for review from the primary treating physician dated 08/05/2014, the patient had complaints of continued right neck and shoulder pain with numbness and weakness of the right hand. Pain was rated a 7-8/10. The physical exam noted restriction in the cervical and right shoulder range of motion with tenderness over the cervical paraspinal muscles and facet joints from C2-C7. There was decreased sensation in the right hand. Hawkins's, Neer's, Hoffman's, cervical facet loading and right shoulder impingement tests were all positive. The treatment plan recommendations included repeat radiofrequency nerve ablation at C2/3 and C3/4.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right C2-C3 radiofrequency nerve ablation with fluroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Facet Radiofrequency Neurotomy Criteria for use of Cervical Facet. Decision based on Non-

MTUS Citation Official Disability Guidelines (ODG) Criteria for use of Cervical Facet Radiofrequency Neurotomy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cervical Facet Joint Radiofrequency Neurotomy.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested service. The Official Disability Guidelines section on cervical facet radiofrequency neurotomy lists the following criteria: 1. Treatment requires a diagnosis of facet joint pain<sup>2</sup>. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score and documented improvement in function<sup>3</sup>. No more than two joint levels are to be performed at one time<sup>4</sup>. If different regions require neural blockade, these should be performed at intervals of not sooner than one week<sup>5</sup>. There should be a plan of formal rehabilitation in addition to facet joint therapy<sup>6</sup>. While repeat neurotomies may be required, they should not be required at an interval of less than 6 months. The patient has had the procedure before with a documented decrease by 50 % in pain and lasting greater than 11 months. The patient does have the diagnosis of facet joint pain. However, there is no documentation of a formal plan for rehabilitation in addition to facet joint therapy. Therefore criteria as set forth above have not been met and the request is not medically necessary and appropriate.

**Right C3-C4 radiofrequency nerve ablation with fluoroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Facet Radiofrequency Neurotomy Criteria for use Of Cervical Facet. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Criteria for use of Cervical Facet Radiofrequency Neurotomy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS Official Disability Guidelines (ODG) Cervical Facet Radiofrequency Neurotomy.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested service. The Official Disability Guidelines section on cervical facet radiofrequency neurotomy lists the following criteria: 1. Treatment requires diagnosis of facet joint pain<sup>2</sup>. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score and documented improvement in function<sup>3</sup>. No more than two joint levels are to be performed at one time<sup>4</sup>. If different regions require neural blockade, these should be performed at intervals of not sooner than one week<sup>5</sup>. There should be a plan of formal rehabilitation in addition to facet joint therapy<sup>6</sup>. While repeat neurotomies may be required, they should not be required at an interval of less than 6 months. The patient has had the procedure before with a documented decrease by 50 % in pain and lasting greater than 11 months. The patient does have the diagnosis of facet joint pain. However, there is no documentation of a formal plan for rehabilitation in addition to facet joint therapy. Therefore criteria as set forth above have not been met and the request is not medically necessary. The patient has had the procedure before with a documented decrease by 50 % in pain and lasting greater than 11

months. The patient does have the diagnoses of facet joint pain. However, there is no documentation of a formal plan for rehabilitation in addition to facet joint therapy. Therefore criteria as set forth above have not been met and the request is not certified.