

<b>Case Number:</b>	CM14-0040892		
<b>Date Assigned:</b>	06/30/2014	<b>Date of Injury:</b>	09/06/2011
<b>Decision Date:</b>	09/05/2014	<b>UR Denial Date:</b>	03/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/08/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine 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 injured worker is a 58-year-old individual with an original industrial injury on September 5, 2011 the injured worker has chronic shoulder pain, rotator cuff syndrome, and chronic neck pain. The disputed request is for an axillary in suprascapular block with pulsed radiofrequency ablation. A utilization review determination had denied this request, citing that pulsed radiofrequency is not recommended. The reviewer also pointed out that prior conservative care was not clearly outlined in the notes.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right suprascapular and axillary block with pulsed radiofrequency:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Nerve Blocks.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pulsed Radiofrequency Section, page(s) 102 Page(s): 102.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines on pages 106-107 state the following regarding pulsed radiofrequency ablation: "Not recommended. Pulsed radiofrequency treatment (PRF) has been investigated as a potentially less harmful alternative to radiofrequency

(RF) thermal neurolytic destruction (thermocoagulation) in the management of certain chronic pain syndromes such as facet joint pain and trigeminal neuralgia. Pulsed radiofrequency treatment is considered investigational/not medically necessary for the treatment of chronic pain syndromes. (BlueCross, 2005) A decrease in pain was observed in patients with herniated disc and spinal stenosis, but not in those with failed back surgery syndrome. However, this option does not appear to be an ideal modality of treatment for lumbar radicular pain because neurodestructive methods for the treatment of neuropathic pain are in principle generally considered inappropriate. In this case, the guidelines of the California Medical Treatment and Utilization Schedule take precedence over other pain guidelines. There is explicit non-recommendation of this procedure and it is not considered medically necessary. There is a lack of quality evidence-based research to support this intervention.