

Case Number:	CM14-0185483		
Date Assigned:	11/13/2014	Date of Injury:	11/01/2007
Decision Date:	01/30/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/07/2014

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 Rehab, 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:

The patient is a 57-year-old female with a date of injury of 11/01/2007. According to progress report dated 08/05/2014, the patient presents with chronic right shoulder and neck pain. It was noted that her pain management specialist has recommended a Rhizotomy for her chronic pain. The patient's surgical history includes carpal tunnel release in the right hand; date of surgery is not indicated. The patient's current medication includes clonazepam, gabapentin, metformin, metoprolol, Norco, and Pristiq. Examination revealed tenderness along the anterior lateral acromion. There is pain and weakness with drop arm test. There is pain and associated weakness with O'Brien's test. Forward flexion and abduction are limited by pain. The listed diagnoses are: 1. Right shoulder impingement syndrome and partial-thickness rotator cuff tear. 2. Right ulnar nerve irritation, rule out cubital tunnel syndrome. 3. Status post left ulnar nerve release at the elbow and wrist. 4. Status post radial tunnel release. 5. Left palmar hand mass. 6. Chronic pain. The utilization review letter dated 10/28/2014 discusses a progress report dated 10/06/2014 which was not provided for my review. According to this report, the patient has diagnoses of cervical spine stenosis, cervical spine facet syndrome, and myofascial pain. The patient is status post radiofrequency ablation on 09/11/2014 and reports "70%-80% pain relief with no side effects." Objective findings revealed paraspinal palpation from the base of the cranium to T1, including the rhomboids and trapezius areas which indicates severe tenderness and spasm bilaterally. Range of motion was decreased in all planes. Sensory exam in the C5, C6, C7, and C8 nerve distribution are all decreased in the right and left. DTRs are decreased to 1/4 bilaterally. This is a request for repeat radiofrequency ablation in the bilateral C6-C7 and C7-T1. The utilization review denied the request on 10/28/2014. The medical file provided for review includes treatment reports and QME reports dating from 04/29/2014 through 08/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat radiofrequency ablation bilateral C6-7: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Chapter, Facet Joint Radiofrequency Neurotomy

Decision rationale: This patient presents with chronic neck and shoulder pain. The current request is for repeat radiofrequency ablation, bilateral C6-C7. The MTUS guidelines do not discuss radiofrequency ablation so the ODG guidelines are referenced. ODG under the Neck and Upper Back chapter states RF ablation is under study, and there are conflicting evidence available as to the efficacy of this procedure and approval of treatment should be made on a case by case basis. Specific criteria are used including diagnosis of facet pain with adequate diagnostic blocks, no more than 2 levels to be performed at 1 time and evidence of formal conservative care in addition to the facet joint therapy is required. An adequate diagnostic block requires greater than 70% reduction of pain for the duration of anesthetic agent used. Medical records indicate that the patient underwent a bilateral radiofrequency on 09/11/2014 which produced 70% to 80% relief. ODG Guidelines states that "while repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from first procedure is documented for at least 12 weeks at greater than 50% relief." The current literature does not support that the procedure is successful without sustained period relief (generally of at least 6 months duration). In this case, the treating physician has noted a 70% to 80% pain relief on 10/07/2014 from an injection that was administered on 09/11/2014. At least 6 months duration of pain relief must be documented for repeat injections. This request is not medically necessary.

Repeat radiofrequency ablation bilateral C7-T1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Chapter, Facet Joint radiofrequency neurotomy.

Decision rationale: This patient presents with chronic neck and shoulder pain. The current request is for repeat radiofrequency ablation, bilateral C6-C7. The MTUS guidelines do not discuss radiofrequency ablation so the ODG guidelines are referenced. ODG under the Neck and Upper Back chapter states RF ablation is under study, and there are conflicting evidence available as to the efficacy of this procedure and approval of treatment should be made on a case

by case basis. Specific criteria are used including diagnosis of facet pain with adequate diagnostic blocks, no more than 2 levels to be performed at 1 time and evidence of formal conservative care in addition to the facet joint therapy is required. An adequate diagnostic block requires greater than 70% reduction of pain for the duration of anesthetic agent used. Medical records indicate that the patient underwent a bilateral radiofrequency on 09/11/2014 which produced 70% to 80% relief. ODG Guidelines states that "while repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from first procedure is documented for at least 12 weeks at greater than 50% relief." The current literature does not support that the procedure is successful without sustained period relief (generally of at least 6 months duration). In this case, the treating physician has noted a 70% to 80% pain relief on 10/07/2014 from an injection that was administered on 09/11/2014. At least 6 months duration of pain relief must be documented for repeat injections. This request is not medically necessary.