

<b>Case Number:</b>	CM15-0014037		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	03/20/2001
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	01/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/24/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Pennsylvania, Ohio, California  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 45 year old male, who sustained an industrial injury on 3/20/2001. He has reported cervical spine injuries after a motor vehicle accident. The diagnoses have included degeneration of cervical intervertebral disc-cervicalgia. Treatment to date has included medications, diagnostics, Transcutaneous Electrical Nerve Stimulation (TENS), cervical traction, and previous radiofrequency rhizotomy on the left performed on 4/8/2002. Currently, the injured worker complains of discomfort in his neck and arm. He also states that his mood has been affected. He continues to struggle with persistent pain and numbness in the left arm. The symptoms are now extending to the right as well. He uses the Transcutaneous Electrical Nerve Stimulation (TENS) and cervical traction on a daily basis. This combination of treatment gives him relief of pain and he is able to sleep. He states the relief is instant but that by the next day the symptoms return. The physical exam revealed pain in the paracervical areas extending to the left. Rotation to the right causes increased pain extending to left shoulder. Extension is also painful. He continues to have discomfort extending on the left arm into the fourth and fifth fingers and reports decreased sensation in this area. Magnetic Resonance Imaging (MRI) of cervical spine dated 12/11/14 revealed posterior bulge and uncovertebral spondylosis with no evidence of herniation or stenosis. The utilization review cited but it was not found in the records provided that the treating physician indicated that the injured worker had a discussion of repeating the radiofrequency ablation as this had helped him in the past a great deal; however, the injured worker indicated that he was not interested in pursuing this at this time as he felt it was temporary, giving him only months of relief. On 1/21/15 Utilization Review non-certified a

request for Radiofrequency ablation left side of cervical spine at C4, C5, C6, C7, noting there was no quantifiable measurement of pain relief from previous radiofrequency ablation and the injured worker indicated he was not interested in pursuing the requested treatment. The report is not supported by the guidelines. The (MTUS) Medical Treatment Utilization Schedule, (ACOEM) Occupational Medicine Practice Guidelines and Official Disability Guidelines (ODG) were cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Radiofrequency ablation left side of cervical spine at C4, C5, C6, C7: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back, Facet joint radiofrequency neurotomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175.

**Decision rationale:** ACOEM Guidelines, Chapter 8, Neck, page 174-175 states that invasive techniques such as cortisone injections for facet mediated pain have no proven benefit in treating neck and upper back symptoms. The medical records in this case discuss that this patient previously underwent invasive treatment in the form of radiofrequency ablation; however, this limited documentation regarding the nature of the benefit from such past radiofrequency ablation. Given the equivocal support for such invasive treatment in the treatment guidelines, as well as the limited documentation and benefit from such past treatment, the medical records at this time do not support an indication for repeating such treatment. This request is not medically necessary.