

Case Number:	CM15-0132208		
Date Assigned:	07/20/2015	Date of Injury:	07/20/2013
Decision Date:	08/19/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	07/09/2015

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: 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 61-year-old female who sustained an industrial injury on 07/20/2013. There was no mechanism of injury documented. The injured worker was diagnosed with cervical facet joint arthropathy, cervical sprain/strain and lumbar facet arthropathy. The injured worker is status post lumbar fusion (no date documented). Treatment to date has included diagnostic testing, epidural steroid injection, bilateral cervical facet joint medial branch block C2-C3 and C3-C4, cervical radiofrequency ablation bilaterally at C2-C3 and C3-C4 in July 2013, physical therapy, cervical pillow and medications. According to the primary treating physician's progress report on June 4, 2015, the injured worker continues to experience bilateral upper neck pain. The injured worker rates her pain level at 8/10. Examination demonstrated tenderness to palpation of the cervical paraspinal muscles overlying the bilateral C2-C3 through C6-C7 facet joints. Cervical range of motion was restricted by pain in all planes. Cervical extension was worse than cervical flexion with positive spasms. Muscle stretch reflexes were 1 and symmetric in all limbs. Hoffman's signs were absent bilaterally. Motor strength and sensation to light touch and pinprick were intact in all limbs. Heel, toe and tandem walk were reported within normal limits. Waddell's signs were negative bilaterally. Current medication was listed as Hydrocodone. Treatment plan consists of continuing with full time modified work duties, stretching exercises, medications and the current request for repeat fluoroscopically-guided C2-3, C3-4 bilateral facet joint radiofrequency nerve ablation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat fluoroscopically-guided bilateral C2-3 and bilateral C3-4 and bilateral facet bilateral facet joint radiofrequency nerve ablation: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines -Neck and Upper Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, under Facet joint radiofrequency neurotomy.

Decision rationale: The 61-year-old patient complains of bilateral neck pain, rated at 8/10, as per progress report dated 06/04/15. The request is for Repeat Fluoroscopically-Guided Bilateral C2-3 and Bilateral C3-4 and Bilateral Facet Joint Radiofrequency Nerve Ablation. The RFA for the case is dated 06/12/15, and the patient's date of injury is 07/20/13. The patient is status post lumbar fusion surgery, as per progress report dated 06/04/15. Diagnoses included bilateral upper cervical facet joint pain at C2-3, C3-4; bilateral lower cervical facet joint pain at C4-5, C5-6 and C6-7; cervical facet joint arthropathy, and cervical sprain/strain. The patient is working on modified duty, as per the same progress report. ODG, Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, under Facet joint radiofrequency neurotomy states: "Criteria for use of facet joint radiofrequency neurotomy: 1. Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections). 2. 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 the first procedure is documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief, generally of at least 6 months duration. No more than 3 procedures should be performed in a year's period. 3. Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. 4. No more than two joint levels are to be performed at one time. 5. If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. 6. There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy." In this case, the patient is status post positive fluoroscopically-guided diagnostic right C2-3 and right C3-4 facet joint medial branch block, and status post fluoroscopically-guided bilateral C2-3 and bilateral C3-4 and bilateral facet joint radiofrequency nerve ablation, as per progress report dated 06/04/15. The prior procedure was performed on 10/17/14, as per the operative report. The current request for repeat radiofrequency ablation is noted in progress report dated 06/04/15. The treater states that the previous nerve ablation "provided 90% improvement for 6 months and enabled the patient to return to work FTMD." The patient suffers from non-radicular pain that failed to respond to conservative care. The treater believes that repeat ablation will "more permanently treat the patient's neck pain at C2-C3 and C3-C4." Given the documentation of efficacy of the prior procedure, as required by the ODG, the request appears reasonable and is medically necessary.

