

<b>Case Number:</b>	CM15-0201884		
<b>Date Assigned:</b>	10/16/2015	<b>Date of Injury:</b>	01/17/2003
<b>Decision Date:</b>	12/29/2015	<b>UR Denial Date:</b>	10/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 65 year old female, who sustained an industrial injury on 1-17-03. The injured worker was diagnosed as having adjacent segment facet arthropathy and stenosis at C4-5 and C5-6. Treatment to date has included anterior cervical discectomy and fusion with instrumentation on 5-15-15, cervical epidural injections, physical therapy, and medication including Norco and Naprosyn. Physical exam findings on 9-10-15 included tenderness in the right trapezius near the superior medial border of the scapulae and cervical compression caused a radicular pattern of pain into the C5-6 distribution. On 9-25-15 the treating physician noted "review of her previous MRI scan shows that she has very large facets at C4-5 and C5-6 with mild foraminal narrowing." On 9-25-15, the injured worker complained of neck pain with radiating occipital pain. The treating physician requested authorization for outpatient C4-5 and C5-6 rhizotomies. On 10-5-15 the request was non-certified by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient C4-5 and C5-6 Rhizotomies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care.

**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, Facet joint radiofrequency rhizotomy.

**Decision rationale:** Per MTUS ACOEM, There is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. "Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks" but beyond that MTUS is silent on specific requirements for RF ablation in the cervical spine. Per ODG with regard to facet joint radiofrequency neurotomy: "Under study. Conflicting evidence, which is primarily observational, is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Studies have not demonstrated improved function." The ODG indicates that criteria for cervical facet joint radiofrequency neurotomy are as follows: 1. Treatment requires a diagnosis of facet joint pain. See Facet joint diagnostic blocks. 2. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function. 3. No more than two joint levels are to be performed at one time (See Facet joint diagnostic blocks). 4. If different regions require neural blockade, these should be performed at intervals of not sooner than one week, and preferably 2 weeks for most blocks. 5. There should be evidence of a formal plan of rehabilitation in addition to facet joint therapy. 6. While repeat neurotomies may be required, they should not be required at an interval of less than 6 months from the first procedure. Duration of effect after the first neurotomy should be 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. Upon review of the medical records submitted, there is no evidence that diagnostic blocks have previously been performed or have provided appropriate level of pain relief to meet the criteria for rhizotomy. Absent such, medical necessity cannot be confirmed.