

Case Number:	CM15-0211258		
Date Assigned:	10/30/2015	Date of Injury:	07/27/1999
Decision Date:	12/14/2015	UR Denial Date:	10/23/2015
Priority:	Standard	Application Received:	10/27/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 50 year old female who sustained an industrial injury on 7/27/99. The mechanism of injury was not documented. The 10/24/09 cervical MRI findings documented a 3-4 mm posterior disc protrusion/extrusion at C5/6 with encroachment on the subarachnoid space but no cord compromise. There was encroachment on the left foramen with compromise on the exiting left nerve root contributed by osteophyte formation from the left uncovertebral joint. There was an 8 mm hemangioma on the right side of the body of C6. At C6/7, there was a 1-2 mm posterior disc protrusion with encroachment on the subarachnoid space. There was no compromise on the cord or nerve root in the neural foramen. The facet joints were unremarkable. At C4/5, there was disc dehydration with a 2 mm posterior disc protrusion. There was a high intensity zone consistent with annular tear/fissure with no compromise on the cord or nerve root. The facet joints were unremarkable. At C3/4, there was no posterior disc bulge or protrusion. The facet joints were reports as unremarkable at all cervical levels. The 6/18/15 pain management procedure report documented cervical facet differential diagnostic block under C-arm fluoroscopy at the level of C4/5 and C5/6 and the medial branches of C3, C4, and C5 on the left side. The report indicated that the injured worker received 2 cc of injectate including lidocaine and Dexamethasone at each level. She underwent manipulation under anesthesia after the block. She reported an initial decrease in left neck pain of 80%. The 8/4/15 pain management report cited neck and bilateral shoulder pain with intermittent numbness and tingling to the left upper extremity. Symptoms were reported 6/10 when exacerbated, especially with repetitive upper extremity use. She underwent cervical diagnostic facet block with two full hours of relief,

and partial relief after that. She had started acupuncture and felt that it helped especially with tightness of the shoulders and upper back. There were some limitations of activities of daily living. Physical exam documented mild loss of range of motion with pain on extension, left lateral flexion, and bilateral rotation. There was pain to palpation over the spinous processes of C5 to C7 and the facets of C3 to C5, more on the left, and mild paracervical muscle spasms. There was pain on the suprascapular nerve area. Spurling's test was negative. Tinel's was positive on the left wrist. The diagnosis included cervical disc disease and cervical facet arthropathy from C3 to C6, more on the left. The treatment plan recommended continued acupuncture with possible radiofrequency ablation. The 1/0/6/15 treating physician report cited up to grade 6-7/10 neck and bilateral shoulder pain, worse on the left. Pain was worse with activities of daily living, turning, twisting or use of the left upper extremity. She was having difficulty sleeping. Physical exam was unchanged from prior report. The injured worker had a good response to the diagnostic facet block with two full hours of relief. She had marked limitation in activities of daily living and she had failed conservative treatment with no major persistent relief. Authorization was requested for cervical percutaneous stereotactic radiofrequency rhizotomy under C-arm fluoroscopy at level of the C4/5 and C5/6 medial branches. The 10/23/15 utilization review non-certified the request for cervical percutaneous stereotactic radiofrequency rhizotomy under C-arm fluoroscopy at level of the C4/5 and C5/6 medial branches as the patient underwent manipulation under anesthesia following the procedure and this could compromise the results of the medial branch blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical percutaneous stereotactic radiofrequency rhizotomy under C-arm fluoroscopy at level of C4-5, C5-6 medial branches: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter (updated 06/25/15) Facet Joint Diagnostic Blocks, Facet Joint Radiofrequency Neurotomy.

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 diagnostic blocks, Facet joint radiofrequency neurotomy.

Decision rationale: The California MTUS guidelines do not provide recommendations for cervical radiofrequency neurotomy. The Official Disability Guidelines indicate that cervical facet joint radiofrequency neurotomy is under study with conflicting evidence as to the efficacy of this procedure. Criteria for the use of cervical facet radiofrequency neurotomy include a diagnosis of facet joint pain using diagnostic blocks, documented improvement in pain scores and function with diagnostic blocks, no more than 2 joint levels at one time, and evidence of a formal plan of rehabilitation in addition to facet joint therapy. Guidelines recommend volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy. Guidelines state the one set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be

approximately 2 hours for Lidocaine. Guidelines limit diagnostic blocks to patients with cervical pain that is non- radicular. Guideline criteria have not been met. This injured worker presents with neck and bilateral shoulder pain with intermittent numbness and tingling into the upper extremities. There is no imaging evidence of facet arthropathy at any cervical spine level. There is imaging evidence of disc pathology, including nerve root compromise, at the requested injection levels. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. The medial branch block procedure did not follow was performed in conjunction with manipulation under anesthesia (which could affect the results of the diagnostic block.) Additionally, there is no evidence of a current forma plan of rehabilitation in addition to the facet joint therapy. Therefore, this request is not medically necessary.