

Case Number:	CM14-0121921		
Date Assigned:	09/16/2014	Date of Injury:	10/22/2013
Decision Date:	10/21/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/01/2014

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 and Rehabilitation and Pain Medicine, 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 injured worker is a 50-year-old female who reported an injury on 10/22/2013 while working in a classroom setting, she was involved in an altercation, holding a combative student down. A book or something was thrown at her and hit her in the right scapular area. Diagnoses were cervical spondylosis, cervicgia, neck sprain, anterior longitudinal (ligament), cervical, atlanto axial (joint). Past treatments have been physical therapy, TENS unit, facet joint injections, and rhizotomy. Diagnostic studies were MRI of the cervical spine that revealed small posterior disc bulge at C6-7 without significant central canal or neural foraminal stenosis. Otherwise, normal cervical spine. The injured worker had a previous rhizotomy. The injured worker was in the emergency department on 04/08/2014 with complaints of a reaction from epidural steroid injection to her lower neck 4 days prior. There were complaints of nausea, frontal headache, and numbness that radiated down both upper extremities. Physical examination on 05/12/2014 revealed that the injured worker obtained some degree of relief of pain from the injection. Medications were not reported. Treatment plan was for rhizotomy at C4-5, C5-6, facet injection with pain management physician. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

RHIZOTOMY C4-5, C5-6 FACET INJECTION WITH PAIN MANAGEMENT PHYSICIAN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Facet injection.

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 Neurotomy

Decision rationale: The decision for RHIZOTOMY C4-5, C5-6 FACET INJECTION WITH PAIN MANAGEMENT PHYSICIAN is not medically necessary. The Official Disability Guidelines state for facet joint radiofrequency neurotomy is under study. There is conflicting evidence, which is primarily observational, available as to the efficacy of this procedure and approval of treatment should be made on a case by case basis. The criteria for use of cervical facet radiofrequency neurotomy are treatment requires a diagnosis of facet joint pain and approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function. No more than two joint levels are to be performed at one time. 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. There should be evidence of a formal plan of rehabilitation in addition to facet joint therapy. 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 greater than 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. A physical examination was not performed on the injured worker after the previous rhizotomy. The injured worker had to go to the emergency room after the previous rhizotomy with complaints of nausea, headache, and dizziness. It is unknown how long the injured worker had relief, or the percentage of pain relief, which was not reported. The clinical information submitted for review does not provide evidence to justify a second rhizotomy. Therefore, this request is not medically necessary.