MAXIMUS Federal Services

Case Number:	CM15-0122237		
Date Assigned:	07/06/2015	Date of Injury:	06/25/2003
Decision Date:	07/31/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	06/24/2015

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: New Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 62-year-old male, who sustained an industrial injury on 6/25/03. He reported neck pain. The injured worker was diagnosed with central disc disruption at C6-C7 and mild disc protrusions at C5-C6 with no signs of cord compression. Treatment to date has included CT scan, MRI, nerve conduction study, surgery, radiofrequency neurotomy and home exercise program. Currently, the injured worker complains of occasional sharp pain that will increase with activities like driving and sitting for prolonged periods. He reports mild left calf weakness. He describes his pain as sharp, throbbing, stabbing, numbness, stinging, cramping and weakness and rates it at 3-5/10. He is diagnosed with lumbosacral degenerative disc disease with radiculopathy, lumbar radiculopathy, cervicalgia, rotator cuff syndrome, low back pain (chronic), cervical spondylosis, cervical spine degenerative disc disease, carpal tunnel syndrome (bilaterally), hypertension and opioid drug dependency. His work status is permanent and stationary. A note dated 5/28/15 states the injured worker experiences cervical pain with palpation and stiffness and tenderness with end range of motion. It also states there is thoracic tenderness to palpation noted at T7-T10. The lumbar/sacral exam revealed tenderness to palpation, poor pelvic rotation and stiffness/tenderness in the thoracolumbar spine at end of range of motion. The injured worker has trouble with toe walking. His motor examination did not reveal any deficits, there were however; sensory deficits noted. The shoulder exam bilaterally revealed tenderness to palpation. The note also states the injured worker experienced beneficial efficacy from previous radiofrequency neurotomy, in 2011, of 50% for greater than one year. He was able to manage is pain symptoms with medication and topical therapy. The

injured worker is experiencing an increase in pain due to a change in his home activities and recent travel. The treatment, MD radiofrequency nuerotomy C4-C5 then (B) C6-C7 one week later, is being requested to assist in alleviating the injured workers pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

(B) MB Radiofrequencies nuerotomy C4-5 then (B) C6-7 1 week later: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Facet joint radiofrequency neurotomy. http://www.odg-twc.com/index.html.

Decision rationale: According to ODG guidelines, radiofrequency ablation 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. One randomized controlled trial was performed on patients with neck pain at the C3 to C7 level after a motor vehicle collision. There was a success rate of 75% with one or two treatments with a median time to return to a 50% preoperative level of pain of approximately 9 months. (Lord, 1996) A similar duration of pain relief (219 days) was found in a prospective non-randomized trial. Complete pain relief was obtained by 71% of patients (for a "clinically satisfying period"). (McDonald, 1999) A recent retrospective review was conducted on patients with diagnosed cervical facet syndrome (via controlled blocks) and found that 80% of patients had pain relief with a mean duration of 35 weeks per injection. The mean duration of relief was less at the C2-3 joint than at other levels, and was also less for patients on compensation (non-significant difference). Pain was not measured with a formal pain-rating instrument. (Barnsley, 2005) (ConlinII, 2005) The procedure is not recommended to treat cervicogenic headaches (See Facet Joint radiofrequency neurotomy, Cervicogenic Headaches). This procedure is commonly used to provide a window of pain relief allowing for participation in active therapy. Complications: Potential side effects include painful cutaneous dysesthesias, increased pain due to neuritis or neurogenic inflammation, and cutaneous hyperesthesia. (Boswell, 2005) The clinician must be aware of the risk of developing a differentiation centralized pain syndrome as a complication of this and other neuroablative procedures. (Washington, 2005) (Haldeman, 2008) (van Eerd, 2010) (Caragee, 2009) (Kirpalani, 2008) (Manchikanti, 2008) Factors associated with failed treatment: These include increased pain with hyperextension and axial rotation (facet loading), longer duration of pain and disability, significant opioid dependence, and history of back surgery. See also Cervicogenic headache, facet joint neurotomy. See the Low Back Chapter for further references. Criteria for use of cervical facet radiofrequency neurotomy: 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. According to the patient file, there is a documentation that cervical radiculopathy was excluded which exclude performing a rhizotomy. In addition, the patient the previous radiofrequency ablation did not show objective functional improvement or significant reduction of pain medications. Cervical facets were not identified as the main pain generator. Furthermore, there is no documentation of a formal plan of rehabilitation in addition to facet joint therapy. There no rational form doing facet injections separated by one week interval. Therefore, the request for (B) MB Radiofrequencies nuerotomy C4-5 then (B) C6-7 1 week later is not medically necessary.