MAXIMUS Federal Services

Case Number:	CM15-0129250		
Date Assigned:	07/15/2015	Date of Injury:	10/03/2013
Decision Date:	08/17/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	07/02/2015

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 40-year-old male who sustained an industrial injury on 10/03/13. He reported right shoulder and neck pain. Initial diagnoses are not available. The injured worker is status post anterior cervical discectomy and fusion C6-C7. Current diagnoses include cervicalgia. Diagnostic testing and treatment to date has included radiographic imaging, and anti-inflammatory medication. Currently, the injured worker reports his neck pain is down to a 3 on a 10 point pain scale; he still has some mild radiating pain going down his right arm, and has numbness in his hand. Physical examination is remarkable for decreased sensation in the right arm, with positive medial nerve test, Phalen test, and cubital tunnel test. Requested treatments include Injection radiofrequency ablation of mid thoracic facet joint Qty: 2. The injured worker's status is full duty. Date of Utilization Review: 06/0515.

IMR ISSUES, DECISIONS AND RATIONALES

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

Injection radiofrequency ablation of mid thoracic facet joint QTY: 2: 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 & Upper Back Chapter.

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: 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 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 deafferentation 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. There is no documentation that the patient developed thoracic facets pain. There is no documentation of a positive medial branch block. In addition, there is no documentation to identify facet as the main pain generator. Furthermore, there is no documentation of a formal plan of rehabilitation in addition to facet joint therapy. Therefore, the request for Injection radiofrequency ablation of mid thoracic facet joint QTY: 2 is not medically necessary.