

Case Number:	CM15-0173243		
Date Assigned:	09/15/2015	Date of Injury:	10/28/2014
Decision Date:	10/23/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/02/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 58 year old male, who sustained an industrial injury on October 28, 2014. The injured worker was diagnosed as having myofascial syndrome and cervical facet syndrome along with cervical spondylosis without myelopathy. Treatment and diagnostic studies to date has included medication regimen, acupuncture, physical therapy, magnetic resonance imaging of the neck performed in 2013 and 2015, magnetic resonance imaging of the back performed in 2014, x-rays performed in 2013, laser therapy, magnetic resonance imaging of the shoulder, and status post bilateral cervical four to five and cervical five to six medial branch block. In a progress note dated August 14, 2015 the treating physician reports complaints of dull, pressure, sharp, and throbbing pain to the neck and lower back. Examination performed on August 14, 2015 was revealing for tenderness to the cervical spine, manubriosternal joint, paracervical muscles, rhomboid muscles, sternoclavicular joint, and trapezius muscles, positive facet mediated pain to the cervical four through six region, positive facet loading maneuvers, decreased range of motion to the cervical spine with pain, pain with Spurling's maneuver to the neck muscles, and tenderness to the cervical four, five, and six spinous processes. On August 14, 2015 the injured worker's current pain level was rated a 9 out of 10, the pain level at its worst was rated a 10 out of 10, and the pain level at its best was rated an 8 out of 10. On August 14, 2015 the treating physician noted that the injured worker was unable to perform activities of daily living such as house chores, activities of socialization, exercises, and has difficulty driving secondary to pain. On August 14, 2015 the treating physician noted that magnetic resonance imaging of the cervical spine performed on June 17, 2015 was revealing for "cervical four

through five spondylotic ridge and facet arthropathy also seen at cervical five to six and at cervical six to seven level". On August 14, 2015, the treating physician noted prior bilateral cervical four to five and cervical five to six medial branch block performed on July 31, 2015 provided pain relief of greater than 75%. On August 14, 2015, the treating physician requested bilateral third occipital cervical three, cervical four, and cervical five radiofrequency ablation noting that the injured worker had "significant relief from above noted medial branch block. On August 31, 2015, the Utilization Review determined the request for bilateral third occipital cervical three, cervical four, and cervical five radiofrequency ablation with a quantity of two to be non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral third Occipital C3, C4, C5 radiofrequency ablation x 2: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Head Chapter (Online version) Greater occipital nerve blocks (GONB); (ODG) Neck Chapter, Greater occipital nerve block, therapeutic, diagnostic.

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 (Acute & Chronic) Chapter, under Facet joint diagnostic blocks.

Decision rationale: The 58 year old patient complains of pain in cervical and lumbar spine, as per progress report dated 08/19/15. The request is for bilateral third occipital C3, C4, C5 radiofrequency ablation X 2. The RFA for this case is dated 08/24/15, and the patient's date of injury is 10/28/14. Diagnoses, as per progress report dated 08/19/15, included cervical sprain/strain with spondylosis, neural foraminal narrowing, disc disease, and complaint of radiculopathy; and lumbar sprain/strain with disk disease, facet disease, neural foraminal narrowing, and complaint of radiculopathy. Diagnoses, as per progress report dated 08/14/15, included myofascial syndrome /cervical facet syndrome and cervical spondylosis. The patient is on modified duty, as per progress report dated 08/19/15. ODG-TWC, Neck and Upper Back (Acute & Chronic) Chapter, under Facet joint diagnostic blocks states: "Recommended prior to facet neurotomy (a procedure that is considered under study)". Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 joint levels are injected in one session (see above for medial branch block levels). 8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in

cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level." For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally described as: "1) axial pain, either with no radiation or severely past the shoulders; 2) tenderness to palpation in the paravertebral areas, over the facet region; 3) decreased range of motion, particularly with extension and rotation; and 4) absence of radicular and/or neurologic findings." In this case, the patient is status post medial branch block, as per operative report dated 07/31/15. As per progress report dated 08/14/15, the patient complains of bilateral neck pain without radiation. MRI of the cervical spine, dated 06/17/15, revealed C4-5 spondylosis and facet arthropathy also seen at C5-6 and C6-7 levels. There is no spinal stenosis or previous fusion surgery. Medial branch block led to >75% pain relief. The pain management specialist states "since there is significant pain relief, we will move forward with a bilateral medial branch radiofrequency ablation to the corresponding levels." However, as per progress report dated 08/19/15 from the patient's primary care physician, the patient has been diagnosed with cervical sprain/strain with spondylosis, neural foraminal narrowing, disc disease, and complaint of radiculopathy. Physical examination reveals decreased sensation at C6 and C7 dermatomes. ODG does not support radiofrequency ablation in patients with radicular symptoms. Given the contradicting reports from the patient's physicians, the request is not medically necessary.