

Case Number:	CM15-0175679		
Date Assigned:	09/17/2015	Date of Injury:	03/09/2011
Decision Date:	10/27/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/08/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

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 53-year-old male, who sustained an industrial injury on March 9, 2011. On July 22, 2015, the injured worker reported ongoing neck pain and left shoulder pain. He rated his pain an 8 on a 10-point scale. The injured worker had restricted cervical spine range of motion at 15 degrees with extension and left lateral rotation of 45 degrees. He had a positive facet loading of bilateral C3 and C4. On August 19, 2015 the injured worker had a pain management evaluation. He reported neck and left upper extremity pain. He rated his pain a 6-9 on a 10-point scale across the neck and had associated headache. His pain was exacerbated by extension and twisting and was constant in nature. The injured worker noted pain radiating to the suprascapular area on a constant basis. He reported difficulty with sleep and noted that he is constantly adjusting his position to adopt a comfortable position. The injured worker's medications included ibuprofen 800 mg, pravastatin sodium 40 mg tablets and Pristiq 100 mg tablets. On physical examination, the injured worker had mild cervical lordosis. His cervical spine range of motion was restricted with extension to 15 degrees due to pain and with lateral rotation to the left at 45 degrees. Spurling's maneuver produced no pain in the neck musculature or radicular symptoms in the arm. He had a positive facet loading of bilateral C3 and C4 concordant with pain. He had a positive Adson's maneuver on the left. The injured worker was diagnosed as having chronic pain syndrome and cervicgia. Treatment to date has included cervical fusion, which provided 80% improvement in radicular symptoms, and previous bilateral C3 and C4 medial branch block on July 6, 2012, which provided 80% relief of pain and cephalgia. A request for authorization for bilateral C3 radiofrequency and bilateral C4

radiofrequency was received on August 24, 2015. On August 27, 2015, the Utilization Review physician determined bilateral C3 radiofrequency and bilateral C4 radiofrequency were not medically necessary. The patient has had history of cervical spine fusion surgery at C4-5 in February 2012. The medication list include Omeprazole, Trazodone, Atorvastatin, Ibuprofen, Pristiq, Cialis, and Aspirin. Per the note dated 9/8/15, the patient had complaints of pain in neck, left upper back and headache at 5-9/10. The physical examination of the cervical spine revealed tenderness on palpation, limited range of motion. The patient had received acupuncture, trigger point injections and massage therapy for this injury. The patient has had MRI of the cervical spine on 10/21/11 that revealed disc protrusions, central canal stenosis, foraminal narrowing, and degenerative changes. The patient has had history of cerebrovascular accident.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral C3 radiofrequency qty 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck and Back, 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 & Upper Back (updated 06/25/15) Facet joint diagnostic blocks Facet joint radiofrequency neurotomy.

Decision rationale: Bilateral C3 radiofrequency qty 1.00. CA MTUS and ACOEM Guidelines do not address this request. Therefore ODG used. As per cited guideline for facet joint radiofrequency neurotomy "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." 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. As per cited guideline, there should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy, which was not specified in the records provided. Patient has received an unspecified number of conservative treatment and massage therapy visits for this injury until date. Detailed response of the conservative visits was not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. Previous

conservative therapy notes were not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The pt has also had cervical spine fusion surgery at C4-5 in February 2012. Per the cited guidelines, "Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level." The medical necessity of the request for Bilateral C3 radiofrequency qty 1.00 is not fully established in this patient. This request is not medically necessary.

Bilateral C4 radiofrequency qty 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck and Back, 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 & Upper Back (updated 06/25/15) Facet joint diagnostic blocks Facet joint radiofrequency neurotomy.

Decision rationale: Bilateral C4 radiofrequency qty 1.00. CA MTUS and ACOEM Guidelines do not address this request. Therefore ODG used. As per cited guideline for facet joint radiofrequency neurotomy "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." 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. As per cited guideline, there should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy, which was not specified in the records provided. Patient has received an unspecified number of conservative treatment and massage therapy visits for this injury till date. Detailed response of the conservative visits was not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. Previous conservative therapy notes were not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The pt has also had cervical spine fusion surgery at C4-5 in February 2012. Per the cited guidelines, "Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level." The medical necessity of the request for Bilateral C4 radiofrequency qty 1.00 is not fully established in this patient. This request is not medically necessary.

