

Case Number:	CM14-0103619		
Date Assigned:	07/30/2014	Date of Injury:	10/05/2011
Decision Date:	09/26/2014	UR Denial Date:	06/18/2014
Priority:	Standard	Application Received:	07/03/2014

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 Occupational 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 female with date of injury 10/5/2011. Per initial consultation report dated 4/16/2014, the injured worker complains of bilateral neck pain and right shoulder pain. She describes the symptoms as achy in quality and rates them as 8/10 in severity. She has experienced these symptoms as a result of falling and breaking her right shoulder. She has had physical therapy and reports no benefit. She was referred for specialized nonsurgical spine care and pain management consultation and treatment for bilateral neck pain and right shoulder pain. Exacerbating factors are reaching with right arm and moving right arm. Mitigating factors are medications. On exam she is obese, alert, and in no acute distress. She has a surgical scar on her shoulder. There is tenderness upon palpation of the right cervical paraspinal muscles overlying the C4-C5, C5-C6, C6-C7 facet joints and right shoulder. There is full and painless range of motion in all limbs without instability. Right shoulder ranges of motion were restricted by pain in all directions with positive right shoulder impingement signs. Cervical ranges of motion were restricted by pain in all directions. Cervical extension was 20 degrees, flexion was 40 degrees, right lateral rotation was 45 degrees, left lateral rotation was 60 degrees and side bending was 20 degrees. Cervical extension was worse than cervical flexion. Spurlings maneuver was negative bilaterally. Nerve root tension signs were negative bilaterally. Shoulder abduction test was negative bilaterally. Percussion of the neurovascular complex in the supraclavicular fossa and in the medial upper arm was negative bilaterally. Tinel's at the elbow, carpal tunnel, and Guyon's canal was negative bilaterally. Allen's test and Phalen's test were negative bilaterally. Muscle stretch reflexes are 2 and symmetrical bilaterally in all limbs. Closus signs are absent bilaterally. Muscle strength is 5/5 in all limbs. Sensation is intact to light touch, pinprick, proprioception and vibration in all limbs. Heel, toe, and tandem walking were within normal limits. Waddell's signs

were negative bilaterally. Diagnoses include 1) right cervical facet joint pain at C4-C5, C5-C6, C6-C7 2) cervical facet joint arthropathy 3) cervical disc protrusion 4) chronic neck pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right C4-C5 facet joint radiofrequency nerve ablation under fluoroscopy, single level

QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC) Integrated Treatment/Disability Duration Guidelines, Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG), Neck chapter, Facet Joint Radiofrequency Neurotomy section.

Decision rationale: The MTUS Guidelines do not address the use of radiofrequency ablation of the cervical facet joints. The Official Disability Guidelines (ODG) reports that facet joint radiofrequency neurotomy is under study as there is conflicting evidence available as to the efficacy of this procedure. Studies have not demonstrated improved function, however there may be pain reduction from the procedure. Criteria for use of cervical facet radiofrequency neurotomy includes 1) diagnosis of facet joint pain 2) adequate diagnostic blocks by documented improvement in VAS scores and improvement in function 3) no more than two joint levels are to be performed at one time 4) if different regions require neural blockade, they should be performed at intervals not sooner than one week and preferably two weeks for most blocks 5) there should be evidence of a formal plan of rehabilitation in addition to facet joint therapy 6) repeat neurotomies should not be required at an interval less than six months from the first procedure and duration of effects should be at least 12 weeks with 50% or greater relief. In this case, the request is for three levels, which is not supported by these guidelines. Therefore, the request for Right C4-C5 facet joint radiofrequency nerve ablation under fluoroscopy, single level quantity one is not medically necessary.

Right C5-C6 facet joint radiofrequency nerve ablation under fluoroscopy, additional level

QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC) Integrated Treatment/Disability Duration Guidelines, Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck chapter, Facet Joint Radiofrequency Neurotomy section.

Decision rationale: The MTUS Guidelines do not address the use of radiofrequency ablation of the cervical facet joints. The Official Disability Guidelines (ODG) reports that facet joint radiofrequency neurotomy is under study as there is conflicting evidence available as to the efficacy of this procedure. Studies have not demonstrated improved function, however there may be pain reduction from the procedure. Criteria for use of cervical facet radiofrequency neurotomy includes 1) diagnosis of facet joint pain 2) adequate diagnostic blocks by documented improvement in VAS scores and improvement in function 3) no more than two joint levels are to be performed at one time 4) if different regions require neural blockade, they should be performed at intervals not sooner than one week and preferably two weeks for most blocks 5) there should be evidence of a formal plan of rehabilitation in addition to facet joint therapy 6) repeat neurotomies should not be required at an interval less than six months from the first procedure and duration of effects should be at least 12 weeks with 50% or greater relief. The request for three levels is not supported by these guidelines. Therefore, the request for right C6-C7 facet joint radiofrequency nerve ablation under fluoroscopy, additional level quantity one is not medically necessary.

Right C6-C7 facet joint radiofrequency nerve ablation under fluoroscopy, additional level QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC) Integrated Treatment/Disability Duration Guidelines, Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck chapter, Facet Joint Radiofrequency Neurotomy section.

Decision rationale: On 5/29/2014 the injured worker had a cervical diagnostic right facet joint medial branch block of C4-C5, C5-C6, C6-C7 under fluoroscopy guidance with 80% improvement in right neck pain with improved cervical range of motion 30 minutes after injection procedure which lasted greater than two hours. The requesting physician is requesting radiofrequency ablation of these three joint levels. The MTUS Guidelines do not address the use of radiofrequency ablation of the cervical facet joints. The ODG reports that facet joint radiofrequency neurotomy is under study as there is conflicting evidence available as to the efficacy of this procedure. Studies have not demonstrated improved function, however there may be pain reduction from the procedure. Criteria for use of cervical facet radiofrequency neurotomy includes 1) diagnosis of facet joint pain 2) adequate diagnostic blocks by documented improvement in VAS scores and improvement in function 3) no more than two joint levels are to be performed at one time 4) if different regions require neural blockade, they should be performed at intervals not sooner than one week and preferably two weeks for most blocks 5) there should be evidence of a formal plan of rehabilitation in addition to facet joint therapy 6) repeat neurotomies should not be required at an interval less than six months from the first procedure and duration of effects should be at least 12 weeks with 50% or greater relief. This request is for three levels, which is not supported by these guidelines. The request for Right C6-

C7 facet joint radiofrequency nerve ablation under fluoroscopy, additional level QTY: 1.00 is determined to not be medically necessary.

Moderate sedation services QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Emergency Physicians www.acep.org.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck chapter, Facet Joint Radiofrequency Neurotomy section.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Moderate sedation services QTY: 2.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Emergency Physicians www.acep.org.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck chapter, Facet Joint Radiofrequency Neurotomy section.

Decision rationale: This request is for moderate sedation in conjunction with the request for facet joint radiofrequency ablation, which is determined to not be medically necessary. Without the ablation procedure, moderate sedation is not necessary. The request for moderate sedation services QTY: 2.00 is determined to not be medically necessary.

Cortisone injection right shoulder QTY: 1.00: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability guidelines (ODG-TWC) Web Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

Decision rationale: This request is for a right shoulder injection following failure of conservative treatment including physical therapy. The MTUS Guidelines recommend two or three subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome or small tears. Prolonged or frequent use of cortisone injections into the

subacromial space of the shoulder joint is not recommended. Therefore, the request for cortisone injection right shoulders quantity one is determined to be medically necessary.

Medication for the right shoulder injection methylprednisolone acetate, 80mg QTY: 1.00:
Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 213.

Decision rationale: This request is for a right shoulder injection following failure of conservative treatment including physical therapy. The MTUS Guidelines recommend two or three subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome or small tears. Prolonged or frequent use of cortisone injections into the subacromial space of the shoulder joint is not recommended. The request for medication for the right shoulder injection methylprednisolone acetate, 80 mg, quantity one is medically necessary.

Medication for the right shoulder injection lidocaine HCL for intravenous infusion, 10mg QTY:1.00: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 213.

Decision rationale: This request is for a right shoulder injection following failure of conservative treatment including physical therapy. The MTUS Guidelines recommend two or three subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome or small tears. Prolonged or frequent use of cortisone injections into the subacromial space of the shoulder joint are not recommended. Therefore, the request for medication for the right shoulder injection lidocaine HCl for intravenous infusion, 10 mg, quantity one is medically necessary.