

Case Number:	CM14-0106441		
Date Assigned:	07/30/2014	Date of Injury:	08/09/2000
Decision Date:	09/09/2014	UR Denial Date:	06/24/2014
Priority:	Standard	Application Received:	07/09/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 62 year-old individual was reportedly injured on August 9, 2000. The mechanism of injury is noted as trauma to the neck when he was hit by an auger. The most recent progress note, dated June 19, 2014 indicates that there are ongoing complaints of chronic neck pain the physical examination demonstrated the claimant can sit through the evaluation, with no apparent distress. A slow broad-based antalgic gait with decreased range of motion, and decreased range of motion of the right knee due to pain. Multiple diagnoses are noted supporting the diagnosis of chronic pain. The claimant is encouraged to continue activities as tolerated, including Aqua therapy or walking for exercise that daily stretching. A notation is made that the claimant is stable with the current palliative care. A progress note dated March 21, 2014 indicates that the claimant is unable to tolerate morphine sulfate IR at bedtime. And that Ultram for breakthrough pain is not very effective. Itching is reported with the use of all pain medications. Morphine sulfate, CR is working well without intolerable side effects, and the claimant is stretching and walking daily for exercise. Claimant to be and mild distress, with decreased range of motion of the cervical spine. And tenderness bilaterally at C4-5, C5-6, and C6-7 facets. Pain is noted with flexion, hyperextension, rotation, and lateral flexion to either side central obesity is noted. A slow broad-based antalgic gait is reported. Right knee range of motion is decreased due to pain. A radiofrequency destruction, procedure is requested at C4-6 bilaterally. Diagnostic imaging studies are not noted. Previous treatment includes a C6-7, cervical fusion, and radiofrequency ablations at C4-6 bilaterally on November 20, 2013. A request had been made for radiofrequency destruction of the medial branch nerves at C4-6 and was not certified in the pre-authorization process on June 24, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency destruction, medial branch nerves C4-6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Cervical Facet blocks/radiofrequency "Criteria for the use of diagnostic blocks for facet nerve pain".

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG).

Decision rationale: California guidelines support the use of facet joint radiofrequency neurotomy in certain clinical settings where a diagnostic medial branch block has been performed with appropriate documentation of relief. The record indicates that the claimant has previously undergone radiofrequency ablation with no objective documentation evidencing the positive response to the prior injections noted (duration of the effect following the prior neurotomy should note at least 50% improvement for greater than 12 weeks with sustained pain relief generally lasting at least 6 months). Documentation should also evidence a formal plan of rehabilitation in addition to facet therapy. Based on the clinical data available, which lacks appropriate documentation required for guideline support for the proposed C4-6. A bilateral radiofrequency ablation procedure. As such, this request is not medically necessary.