

Case Number:	CM15-0167656		
Date Assigned:	09/09/2015	Date of Injury:	02/22/2001
Decision Date:	10/09/2015	UR Denial Date:	07/24/2015
Priority:	Standard	Application Received:	08/26/2015

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, North Carolina
 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(n) 68 year old male, who sustained an industrial injury on 2-22-01. The injured worker was diagnosed as having cervical disc degeneration and cervical stenosis. The physical exam dated 10-20-15 the injured worker reported neck pain and wanted another cervical radiofrequency procedure. The treating physician indicated that the injured worker would not allow a physical exam of the neck. Treatment to date has included a left C5-C6 radiofrequency lesioning on 7-2-14 and a right C5-C6 radiofrequency lesioning on 4-23-14 with greater than 75% relief for one year, a TENS unit, Fentanyl patch, Baclofen and Xanax. As of the PR2 dated 7-13-15, the injured worker reports a flare-up of neck pain. The treating physician noted exquisite tenderness in the bilateral C5-C6 facets. The treating physician requested a staged radiofrequency lesioning at the C5-C6 level starting with the left and then right one week later. On 7-22-15 the treating physician requested a Utilization Review for a staged radiofrequency lesioning at the C5-C6 level starting with the left and then right one week later. The Utilization Review dated 7-24-15, non-certified the request for a staged radiofrequency lesioning at the C5-C6 level starting with the left and then right one week later.

IMR ISSUES, DECISIONS AND RATIONALES

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

Staged Radiofrequency Lesioning at the C5-C6 Level starting with the Left and then Right One Week Later: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic), Facet joint radiofrequency neurotomy.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Diagnostic Criteria.

Decision rationale: The request is for a repeat bilateral C5-C6 Radiofrequency Ablation (RFA). Guidelines state that RFA should provide at least 50% relief of pain over 12 weeks. Repeat procedures are not indicated if there is a lack of the above mentioned improvement. In this case, documentation dated 7/13/15 shows subjective complaints of a flare-up of neck pain. Objectively, the patient has exquisite tenderness of the facet joints bilaterally at C5-C6. The patient's diagnosis is degenerative cervical disc disease and cervical spinal stenosis. A progress note dated 7/28/2014 noted only 30% improvement following the previous RFA. This falls below the guidelines for a repeat procedure, therefore the request is not medically necessary or appropriate.