

Case Number:	CM14-0172526		
Date Assigned:	10/23/2014	Date of Injury:	02/15/1992
Decision Date:	11/25/2014	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	10/17/2014

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 New York. 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 72-year-old male with a reported injury on 02/15/1992. The mechanism of injury was a motor vehicle accident. His diagnoses were noted to include lumbar postlaminectomy syndrome and cervical postlaminectomy syndrome. His previous treatments have included medications, physical therapy, cervical epidural steroid injections, acupuncture, diagnostic blocks to multiple levels of the lumbar spine, cervical and lumbar facet blocks, cervical neurotomy, L5 block for pedicle screw, facet blocks at C4-7 and the use of a TENS unit and medial branch neurotomies C4-7 on 09/06/2005. Of note, the injured worker had an epidural steroid injection at L5-S1 on 02/12/2013, which resulted in an 80% decrease in pain times 4 months. He also had a lumbar epidural steroid injection on 12/03/2013, which helped the left sided low back pain, but not the right sided low back pain. He had resumed his medications by 01/13/2014. The injured worker's diagnostic testing was noted to include cervical spine x-rays on 05/10/1999; lumbar spine CT in 03/2010; an undated CT of the cervical spine; cervical discography on 11/18/1997; an MRI of the lumbar spine on 04/27/1993; CT of the lumbar spine on 08/13/2008; an MRI of the lumbar spine on 10/15/2010; and an MRI of the lumbar spine on 08/14/2014, which revealed mild to moderate degenerative joint disease with changes most prominent at C4-5; post therapy changes at C5-6 with fusion and satisfactory postop appearance with no recurrent disease and no spinal or neural foraminal narrowing; bilateral neural foraminal disc protrusion and osteophyte complex, moderate bilateral C4-5, mild bilateral C3-4 as above with neural foraminal narrowing in combination with facet joint and uncovertebral arthropathy; degenerative type central spinal canal narrowing, mild C3-4, C4-5 and C6-7; no fractures or bony lesions; spinal cord was normal. The injured worker's surgical history included thumb, left foot and left ankle, undated surgeries; an undated cervical spine fusion; a decompression/revision fusion of the lumbar spine at multiple levels on 10/27/2008, bilateral carpal tunnel releases;

exploration of the right posterior tibial tendon on 12/23/1994. The injured worker was evaluated for neck and lower back pain on 10/09/2014. The injured worker continued to complain of severe neck pain, as well as radicular symptoms into his left upper extremity. He noted tingling and weakness, particularly in the left arm that extended into the first 3 digits of the left hand. He was recently approved and scheduled for bilateral cervical radiofrequency ablation at C4-5 and C5-6 to be done on 11/04/2014. Regarding his lower back pain, the injured worker continued to note ongoing lower back pain that bothers him less than his neck pain. He rated his low back pain at 6/10, made worse with extended periods of activity and better with rest and medication, specifically Lidoderm patches. The injured worker requested lumbar epidural steroid injections, which the clinician states would be considered after the cervical radiofrequency ablation. Regarding medication, the injured worker continued to utilize approximately 6 Percocet per day; with this medication he was able to complete his activities of daily living including fishing, getting out of his house and getting out of bed. Lidoderm patches allowed him to bend and twist more at his lumbar spine. With the use of his medication the pain in his neck decreased down to 3/10. The injured worker denied side effects with the use of these medications. The injured worker had continued pain relief, as well as functional improvement with the use of these medications. The clinician's treatment plan was to have cervical radiofrequency ablation on 11/04/2014. Regarding the lower back pain, the injured worker would like to have a repeat lumbar epidural steroid injection sometime after the cervical radiofrequency ablation. Regarding medication, the plan was to consider tapering down oral medications after the radiofrequency ablation of the cervical spine and most likely repeat lumbar epidural steroid injections of his lumbar spine. There was no aberrant behavior and he has not self increased his medications. His history was consistent. Medications were refilled. The injured worker's medications included Lidoderm 5% patches, apply 2 patches 12 hours on and 12 hours off, Flexeril 10 mg 1 to 2 at night as needed for spasm, Percocet 5/325 mg every 6 hours as needed for pain, Topamax 50 mg twice a day and capsaicin 0.025% cream topically on to affected area as needed. The Request for Authorization of Lidoderm 5% patches #90 with 3 refills and 1 bilateral permanent cervical facet joint injection at C5-6 (AKA radiofrequency ablation) each additional level arthrogram under fluoroscopic guidance and IV sedation and arthrogram/IV sedation for level C4-5, modified to 1 bilateral permanent cervical facet joint injection at C5-6 (AKA radiofrequency ablation) each additional level arthrogram under fluoroscopic guidance was submitted on 10/16/2014. No rationale for this request was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for Lidoderm 5% patch #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: The request for 1 prescription for Lidoderm 5% patch #90 with 3 refills is not medically necessary. The injured worker continued to complain of neck and lumbar spine

pain. The California MTUS Chronic Pain Guidelines recommend topical lidocaine in the formulation of a dermal patch for localized peripheral neuropathic pain after there has been evidence of a trial of first line therapy, such as an antidepressant or antiepileptic. The provided documentation did not indicate the trial and failure of anticonvulsant or antiepileptic drugs. Additionally, the request did not indicate a site or frequency of application and 3 refills would not be appropriate without evaluation of efficacy. Therefore, the request for 1 prescription for Lidoderm 5% patch #90 with 3 refills is not medically necessary.

1 bilateral permanent cervical facet joint injection at C5-C6 (AKA radiofrequency ablation) each additional level, arthrogram, under Fluoroscopic Guidance and IV sedation, and arthrogram/IV sedation for level C4-5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation (ODG) Neck and Upper Back (Acute & Chronic), Facet joint radiofrequency neurotomy.

Decision rationale: The request for 1 bilateral permanent cervical facet joint injection at C5-6 (AKA radiofrequency ablation) each additional level, arthrogram, under fluoroscopic guidance and IV sedation, and arthrogram/IV sedation for level C4-5 is not medically necessary. The injured worker complained of neck and lower back pain. The California Medical Treatment Utilization Schedule/ACOEM Guidelines state there is limited evidence regarding the efficacy of radio-frequency neurotomy for chronic neck pain. The Official Disability Guidelines state, prior to a diagnostic block for facet nerve pain, the clinical presentation should be consistent with facet joint pain, signs, and symptoms. There is no documentation of facet mediated pain upon physical examination. The guidelines also indicate that diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. It is noted that the injured worker is status post C5-6 fusion. The patient had medial branch neurotomies at C4-7 on 09/06/2005 but no documentation of results was provided. As the primary treatment of permanent cervical facet joint injection at C5-6, the ancillary arthrogram, fluoroscopic guidance, and IV sedation are not supported. Therefore, the request for 1 bilateral permanent cervical facet joint injection at C5-6 (AKA radiofrequency ablation) each additional level, arthrogram, under fluoroscopic guidance and IV sedation, and arthrogram/IV sedation for level C4-5 is not medically necessary.