

<b>Case Number:</b>	CM14-0048886		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	10/24/2010
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2014

### 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 Medical & Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 53-year-old male with a date of injury of 10/24/2010. The injured worker's diagnosis include stenosis, lumbar spine; lumbar radiculopathy; gastroparesis; sprain/strain, neck; facet arthropathy, cervical; cubital tunnel syndrome; degenerative disk disease, thoracic spine; migraine; cervical radiculopathy, left; degenerative disk disease, cervical. According to progress report dated 01/08/2014, the injured worker presents with pain in the lower back which is increasing however, stated that medication regimen is giving him pain control to continue with his activities of daily living. The injured worker complains of left cephalgia and cervicalgia migraines and has a flare-up of right sciatica. The patient's medication regimen includes AndroGel pump 20.25 mg, Norco 10/325 mg, Lidoderm 5% patch, Lexapro, Klonopin 0.5 mg, and Ambien 10 mg. Examination of the cervical spine revealed abnormal palpation and tenderness at T4 to T5. There was moderate bilateral parathoracic tenderness noted. ROM was within normal range. The treating physician states he will start the injured worker on AndroGel pump 20.25 mg/ACT (1.62%) gel. The request is for AndroGel gel, left radiofrequency ablation C5-C6, left radiofrequency ablation C6-C7, anesthesia and fluoroscopic guidance for all procedures and radiologic examination for the cervical spine. The utilization review denied the 03/13/2014 request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AndroGel Spray 1.62% QTY: 6.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone Replacement for Hypogonadism Page(s): 110-111.

**MAXIMUS guideline:** The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines and Food and Drug Administration (FDA).

**Decision rationale:** This injured worker presents with pain in the lower back which is increasing. The medical file provided for review does not provide a rationale for why this medication is being prescribed. The MTUS, ACOEM and ODG guidelines do not discuss Androgel spray. Therefore, an alternative resource was consulted. The Food and Drug Administration (FDA) has the following regarding Androgel. "Androgel 1.62% is a prescription medicine that contains testosterone. 1.62% is used to treat adult males who have low or no testosterone. It is recommended that healthcare provider's test patient's blood before they start and while they are taking Androgel 1.62%." Official Disability Guidelines (ODG), states testosterone is, "recommended in limited circumstances for patients taking high-dose long-term opioids with documented low testosterone levels." In this case, the treating physician does not provide the patient's testosterone levels, nor evidence of gynecomastia on exam. Furthermore, there are no reports of blood tests prior to initiating this medication. Given the lack of discussion of patient's testosterone levels the Androgel spray is not medically necessary.

#### **Left Radiofrequency Ablation at C5-C6 QTY: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG).

**Decision rationale:** This patient presents with pain in the lower back which is increasing. The treating physician is requesting a left radiofrequency ablation at level C5-C6. ACOEM Guidelines page 300 and 301 states, "Lumbar facet neurotomies reportedly produce mixed results". For more thorough discussion, Official Disability Guidelines (ODG) is referenced. The ODG states RF ablation is under study and there is conflicting evidence available as to the efficacy of this procedure. In addition, approval of treatment should be made on a case by case basis. Specific criteria are used including diagnosis of facet pain with adequate diagnostic blocks, no more than 2 levels to be performed at 1 time and evidence of formal conservative care in addition to the facet joint therapy is required. An adequate diagnostic block requires greater than 70% reduction of pain for the duration of anesthetic agent used. In this case, the treating physician does not discuss or document diagnostics blocks. ODG recommends radiofrequency only after adequate diagnostics blocks have taken place. Given the lack of documentation of such, recommendation this request is not medically necessary.

#### **Left Radiofrequency Ablation at C6-C7 QTY: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG).

**Decision rationale:** This patient presents with pain in the lower back which is increasing. The treating physician is requesting a left radiofrequency ablation at level C6-C7. ACOEM Guidelines page 300 and 301 states "Lumbar facet neurotomies reportedly produce mixed results". For more thorough discussion, Official Disability Guidelines (ODG) is referenced. ODGO states RF ablation is under study, and there are conflicting evidence available as to the efficacy of this procedure and approval of treatment should be made on a case by case basis. Specific criteria are used including diagnosis of facet pain with adequate diagnostic blocks, no more than 2 levels to be performed at 1 time and evidence of formal conservative care in addition to the facet joint therapy is required. An adequate diagnostic block requires greater than 70% reduction of pain for the duration of anesthetic agent used. In this case, the treating physician does not discuss or document diagnostics blocks. ODG recommends Radiofrequency only after adequate diagnostics blocks have taken place. Given the lack of documentation of such, the request is not medically necessary.

**Anesthesia for all Procedures QTY: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG).

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

**Radiologic Examination, Cervical Spine QTY: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 8 - Neck and Upper Back Complaints, page(s) 177-178 and on the Non-MTUS Official Disability Guidelines (ODG).

**Decision rationale:** This patient presents with pain in the lower back which is increasing. The treating physician is requesting radiologic examination of the cervical spine. ACOEM Guidelines page 177 and 178 has the following criteria for ordering images, "emergence of red flag, physiologic evidence of tissue insult, or neurologic dysfunction; failure to progress strengthening program intended to avoid surgery; and clarification of anatomy prior to invasive procedure." For chronic condition, Official Disability Guidelines (ODG) recommends MRI studies for chronic neck pain after 3 months of consecutive treatment when radiographs are normal and neurological signs or symptoms are present. The progress reports dated 09/17/2013 through 01/08/2014 does not provide a discussion of prior radiographic examination of the cervical spine. The utilization review indicates there is discussion of prior cervical MRI dated 09/18/2012 which revealed a left C6 to C7 disk osteophyte causing moderate left NFSC. This progress report was not provided in the medical file. In this case, there are no concerns for tumor, infection, dislocation, myelopathy, or any other red flag conditions. The patient has evidence of tenderness but there are no progressive neurological deficit noted. There are no radicular symptoms described either. As such, this request is not medically necessary.

**Fluoroscopic Guidance QTY: 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG).

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