MAXIMUS Federal Services

Case Number:	CM15-0187475		
Date Assigned:	09/29/2015	Date of Injury:	04/06/2001
Decision Date:	11/06/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/23/2015

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: Illinois, California, Texas
Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 59-year-old male who sustained an industrial injury on 4/6/01. Injury occurred when he was fixing a ceiling fixture and fell off a ladder. The 3/13/13 upper extremity electrodiagnostic study revealed evidence of bilateral moderate carpal tunnel syndrome. The 4/8/13 cervical spine MRI impression documented disc abnormality and facet arthropathy with focal protrusions noted at T2/3 and T3/4, mild to moderate C5/6 canal stenosis, and mild C6/7 canal stenosis. There was moderate to severe right and moderate left C3/4, moderate right and moderate to severe left C5/6, moderate left C6/7, and mild left C7/T1 mild neuroforaminal narrowing. The injured worker underwent bilateral C5/6 and C6/7 medial branch blocks on 5/22/15 with 100% relief for 5 to 6 hours. A request for bilateral C5/6 and C6/7 rhizotomy was certified on 7/20/15. The 7/29/15 treating physician report cited increased severe left-sided headaches, occurring almost daily for which he was using ice packs, Excedrin, Imitrex and Fioricet. He reported the Imitrex was helpful if he took it when the headache begins, and was taking Fioricet if the Imitrex did not work. He reported neck pain radiating into the first 3 digits of both hands with numbness, pins and needles. Looking over his shoulder, up and down increased the neck pain. Neck pain was increased when he had a headache. He reported low back pain radiating into the groin. He denied any numbness and tingling in the legs. He reported increased pain with bending forward, twisting or crawling. He reported occasional giving out of the right leg. Pain was also increased with sitting, standing and walking for long periods of time. Current medications included Norco, Pamelor, Fioricet, Ketoprofen cream, Excedrin, Naproxen, and Cymbalta. The diagnosis included cervical facet arthropathy, cervical stenosis, cervical

myofascial strain, cervicalgia, and occipital neuralgia. The treatment plan documented refills of Naproxen, Norco, Pamelor, and Imitrex, and prescribed Voltaren gel for use over the occiput. Lidocaine ointment 5% was also prescribed without a documented indication. Authorization was requested for bilateral C5/6 and C6/7 rhizotomy, Lidocaine ointment 5% one tube, and Voltaren gel 1% 4 gm. The injured worker underwent bilateral C5/6 and C6/7 radiofrequency rhizotomy on 8/20/15 with good relief and improved symptoms of 50%. The 9/2/15 utilization review non-certified the request for bilateral C5/6 and C6/7 rhizotomy following discussion with the primary treating physician's office as the procedure had been previously certified and performed on 8/20/15. The request for one tube of Lidocaine ointment 5% was non-certified as guidelines do not recommend any formulation of topical lidocaine other than the dermal patch. The request for Voltaren gel 1% 4 gm was non-certified as the treatment was noted for the management of suboccipital pain which is not supported by guidelines for topical treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral C5-C6 and C6-C7 rhizotomy: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: Facet joint radiofrequency neurotomy.

Decision rationale: The California MTUS guidelines do not provide recommendations for cervical radiofrequency neurotomy. The Official Disability Guidelines indicate that cervical facet joint radiofrequency rhizotomy is under study with conflicting evidence as to the efficacy of this procedure. Criteria for the use of cervical facet radiofrequency rhizotomy include a diagnosis of facet joint pain using diagnostic blocks, documented improvement in pain scores and function with diagnostic blocks, no more than 2 joint levels at one time, and evidence of a formal plan of rehabilitation in addition to facet joint therapy. For repeat injections, pain relief of 50% or more for at least 12 weeks and sustained pain relief of a least 6 months duration should be documented. Guideline criteria have not been met. This injured worker underwent previously certified bilateral C5/6 and C6/7 rhizotomy on 8/20/15, which was less than 4 weeks prior to this request. Guidelines do not support repeat rhizotomy at less than 6 month intervals. Therefore, this request is not medically necessary.

Lidocaine ointment 5% 1 tube: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The California MTUS guidelines do not recommend topical lidocaine ointment for non-neuropathic pain and only Lidocaine in the dermal patch formulation is recommended for neuropathic pain. There is no documented medical indication for the use of topical lidocaine ointment. There is no compelling rationale presented to support an exception to guidelines. Therefore, this request is not medically necessary.

Voltaren gel 1% 4gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain: Diclofenac, topical (Flector, Pennsaid, Voltaren Gel).

Decision rationale: The California MTUS guidelines state Voltaren gel 1% is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. The Official Disability Guidelines state that Voltaren gel is not recommended as a first line treatment, but is recommended as an option for patients at risk of adverse effects from oral non-steroidal anti-inflammatory drugs (NSAIDs) Guideline criteria have not been met. This patient is currently taking the oral NSAID Naproxen with no documented adverse side effects. The current indication is documented as use in the occipital region which is not consistent with guideline recommended use for relief of osteoarthritis of peripheral joints. There is no compelling rationale to support an exception to guidelines. Therefore, this request is not medically necessary.