

Case Number:	CM15-0170055		
Date Assigned:	09/10/2015	Date of Injury:	06/19/2000
Decision Date:	10/30/2015	UR Denial Date:	07/29/2015
Priority:	Standard	Application Received:	08/28/2015

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 56 year old female, who sustained an industrial injury on 6-19-00. The injured worker was diagnosed as having cervical disc disease, cervical facet arthropathy, headaches possible cervicogenic, bilateral carpal tunnel syndrome and diabetes. Treatment to date has included fluoroscopic guided facet joint denervation, epidural cervical steroid injections and activity modifications. (MRI) magnetic resonance imaging of cervical spine performed on 11-22-14 revealed Grade 1 anterolisthesis of C3 on C4, disc desiccation at C2-3 to C7-T1, reversal of normal cervical lordosis, C3-4 focal central disc herniation, C4-5, C5-6 and C6-7 diffuse disc herniation, and facet arthropathy at multiple levels. Currently on 6-25-15, the injured worker complains of right sided neck pain, upper extremity pain and headaches. She notes the pain goes to a level of 5-6 out of 10. She notes after previous cervical epidural steroid injection she had improvement of symptoms lasting over 8 weeks. Physical exam performed on 6-25-15 revealed restricted cervical range of motion with pain on spinous process of C5-7 and facets of C2-3, C3-4 and C5-6 along with pain on right suprascapular nerve area and facet of T1-3 on right. The treatment plan included Ultracet, compound cream of Cymbalta-Lyrica-Diclofenac-Lidocaine-Cyclobenzaprine and radiofrequency facet ablation of right cervical facet at C4-5 and C5-6 on medial branch. On 7-29-15 utilization review denied cervical percutaneous stereotactic radiofrequency rhizotomy C4-5 and C5-6 noting signs and symptoms suggestive of a radiculopathy and no reference to benefit of a facet joint block, Ultracet 37.5mg noting the quantity is not given and compound cream of Cymbalta-Lyrica-Diclofenac-Lidocaine-Cyclobenzaprine due to guidelines noting there is little scientific evidence to support these medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical percutaneous sterrotactic radiofrequency rhizotomy under C-arm fluoroscopy at C4-C5 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, Pain, Diagnostic Blocks.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Rhizotomies.

Decision rationale: California MTUS and ACOEM do not specifically address radiofrequency ablation. The Official Disability Guidelines indicate that facet joint radiofrequency neurotomy treatments typically require a diagnosis of facet joint pain using a medial branch block with initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks. It states that the procedure should not occur at an interval less than six months from the first procedure, and the first procedure should document improvement for at least twelve weeks at greater than 50% reduction of pain and that the procedure should not be repeated unless there is sustained pain relief, generally of at least six months duration. Approval of repeat neurotomies depend on documentation of visual analog pain scale scores, decreased medication usage, and documented improvement in function. Within the submitted records, there is mention of facet diagnostic block at the cervical level performed 10/2013 and facet joint denervation procedure 01/2014 but no mention of positive response as mentioned above, for 6 weeks plus. Guideline criteria have not been met. Medical necessity has not yet been substantiated.

Cervical percutaneous sterroractic radiofrequency rhizotomy under C-arm fluoroscopy at C5-C6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Diagnostic Blocks.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Rhizotomies.

Decision rationale: California MTUS and ACOEM do not specifically address radiofrequency ablation. The Official Disability Guidelines indicate that facet joint radiofrequency neurotomy treatments typically require a diagnosis of facet joint pain using a medial branch block with initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks. It states that the procedure should not occur at an interval less than six months from the first procedure, and the first procedure should document improvement for at least twelve weeks at

greater than 50% reduction of pain and that the procedure should not be repeated unless there is sustained pain relief, generally of at least six months duration. Approval of repeat neurotomies depend on documentation of visual analog pain scale scores, decreased medication usage, and documented improvement in function. Within the submitted records, there is mention of facet diagnostic block at the cervical level performed 10/2013 and facet joint denervation procedure 01/2014 but no mention of positive response as mentioned above, for 6 weeks plus. Guideline criteria have not been met. Medical necessity has not yet been substantiated.

Ultracet 37.5/325mg (QTY unspecified): 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): Opioids for chronic pain, Opioids, criteria for use.

Decision rationale: The California MTUS guidelines allows for the use of opioid medication, such as Ultracet, which a combination medication containing the opioid Tramadol, for the management of chronic pain and outlines clearly the documentation that would support the need for ongoing use of an opioid. These steps include documenting pain and functional improvement using validated measures at 6 months intervals, documenting the presence or absence of any adverse effects, documenting the efficacy of any other treatments and of any other medications used in pain treatment. The 4 A's have not been adequately documented as it pertains to Ultracet. Furthermore, a medication quantity was not specified. Medical necessity has not been established.

Compound Cymbalta/Lyrica/Diclofenac/Lidocaine/Cyclobenzaprine QTY: 1.00: 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: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. There is failure to document that first line antidepressants or anticonvulsants have been tried and failed. Furthermore, topical Lyrica and Cyclobenzaprine are not recommended. Lidocaine is FDA approved for topical treatment in the form of a patch and for the treatment of post-herpetic neuralgia. Medical necessity is not established.