

Case Number:	CM13-0032715		
Date Assigned:	12/06/2013	Date of Injury:	07/28/2011
Decision Date:	02/14/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	10/08/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and Pain Medicine and is licensed to practice in Ohio and Texas. 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 physician 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 42-year-old female who reported an injury on 07/28/2011. The mechanism of injury was stated to be cumulative trauma. The patient was noted to have subjective complaints of a 5/10 of neck pain. The patient was noted to be continuing a home exercise program as tolerated. The patient was noted to have headaches. The patient's diagnoses were noted to include right cervical radiculopathy and facet arthropathy, status post right shoulder subacromial decompression on 03/05/2012 and right elbow cubital tunnel syndrome not electrodiagnostically supported. The request was made for medication refills and a medial branch block at C4, C5 and C6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial branch block C4, C5, C6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Facet joint diagnostic blocks.

Decision rationale: The Official Disability Guidelines recommend that the criteria for diagnostic blocks for facet nerve pain include clinical presentation that is consistent with facet joint pain signs and symptoms; 1 set of diagnostic medial branch blocks is required with a response of greater than 70%, and the pain response should be approximately 2 hours for lidocaine. It is limited to patients with cervical pain that is non-radicular and at no more than 2 levels bilaterally, and there should be documentation of a failure of conservative treatment prior to the procedure for at least 4 to 6 weeks. Additionally, no more than two levels are to be injected in one session, and diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. The clinical documentation submitted for review indicated that the patient was awaiting a cervical spine surgery that had been authorized. It failed to provide the level of the surgical procedure; however, as per guidelines, the request would not be supported due to the planned surgery. Given the above, the request for a medial branch block at C4, C5 and C6 is not medically necessary.

Topiramate 50mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epileptic, Topiramate Page(s): 21. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The Chronic Pain Guidelines indicate that topiramate has been shown to have variable efficacy, with a failure to demonstrate efficacy in neuropathic pain of central etiology. However, it is still considered for use for neuropathic pain when other anticonvulsants have failed. The clinical documentation submitted for review indicated that the patient was using a medication for headaches, and the headaches were improved with Topamax. The Official Disability Guidelines recommend Topamax to prevent migraine headaches in adults. However, there was a lack of documentation of functional benefit for the patient with this medication. Given the above, the request for topiramate 50 mg #30 is not medically necessary.

Hydrocodone 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-80, 81. Decision based on Non-MTUS Citation ODG, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going management and Hydrocodone/acetaminophen Page(s): 78 & 91.

Decision rationale: The Chronic Pain Guidelines indicate that hydrocodone/acetaminophen is indicated for moderate to moderately severe pain, and there should be documentation of the 4 A's for on-going monitoring, including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The clinical documentation submitted for review indicated that the patient was taking Norco 10/325 for pain; however, it failed to provide documentation of the

4 A's to support the ongoing usage. There was a documentation of the necessity for 90 tablets. Given the above, the request for hydrocodone 10/325 mg #90 is not medically necessary.

Tizanidine 4mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63. Decision based on Non-MTUS Citation ODG, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine Page(s): 66.

Decision rationale: The Chronic Pain Guidelines recommend tizanidine (Zanaflex®) as a non-sedating muscle relaxant with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The clinical documentation submitted for review failed to provide the efficacy of the medication. Additionally, it failed to indicate that the patient had trialed a first-line option for the short-term treatment of acute exacerbations. Given the above, the request for tizanidine 4 mg #90 is not medically necessary.