

<b>Case Number:</b>	CM13-0071360		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	07/31/2001
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	12/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/27/2013

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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:

This is a 50 year old female presenting with chronic neck pain following a work related injury on 07/31/2001. On 12/4/2013, the injured worker complained of increased left arm numbness, more consistent headaches, and aching on the left side of the neck. The provider noted that the injured worker had radiofrequency ablation on 03/19/2013 which provided 8 months of 70% relief of neck and shoulder pain with a decrease frequency and severity of headaches. The injured worker reported that the medications did not provide enough pain relief. The physical exam revealed tenderness of the cervical facets on the right and limited cervical range of motion with extension and rotation to the right. The injured worker was diagnosed with left cervical facet pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### (1) LEFT SIDED CERVICAL RADIOFREQUENCY AT C3-C4 AND C4-C5:: Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cervical spine complaints, facet blocks.

**Decision rationale:** 1 left sided cervical radiofrequency at C3-C4 and C4-C5 between 12/4/13 and 2/11/14 is not medically necessary. Per the ACOEM Practice Guidelines above, "facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks." Additionally, the Official Disability Guidelines criteria for use of diagnostic facet blocks require that the clinical presentation be consistent with facet pain. Treatment is also limited to patients with spine pain that is non-radicular and had no more than 2 levels bilaterally documentation of failed conservative therapy including home exercise physical therapy and NSAID is required prior to the diagnostic facet block. There is no documentation that the claimant had left sided diagnostic blocks with quantifiable results of at least 70% reduction in pain prior to the radiofrequency, therefore, the request is not medically necessary.

**(1) PRESCRIPTION OF HYDROCODONE/ACETAMINOPHEN 10/325MG #75:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79.

**Decision rationale:** Hydrocodone/Acetaminophen 10/325mg #75 between 12/4/13 and 2/11/14 is not medically necessary. Per Chronic Pain Medical Treatment Guidelines page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the medical records note that the claimant was permanent and stationary. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore the requested medication is not medically necessary.

**(1) PRESCRIPTION OF OPANA ER 10MG #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines (May 2009).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79.

**Decision rationale:** 1 prescription of Opana ER 10mg #30 between 12/4/13 and 2/11/14 is not medically necessary. Per Chronic Pain Medical Treatment Guidelines page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical

records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the medical records note that the claimant was permanent and stationary. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore the requested medication is not medically necessary.

**VOLTAREN 1% GEL #300:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines (May 2009).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** Voltaren 1% gel is not medically necessary. According to Chronic Pain Medical Treatment Guidelines, chronic pain, page 111 Chronic Pain Medical Treatment Guidelines does not cover "topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended, is not recommended". Additionally, Chronic Pain Medical Treatment Guidelines page 111 states that topical NSAIDs, are indicated for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. It is also recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of pain associated with the spine, hip or shoulder; therefore, the medication is not medically necessary.