

Case Number:	CM14-0109400		
Date Assigned:	08/06/2014	Date of Injury:	06/30/2000
Decision Date:	09/11/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/14/2014

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 Pain Management 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 injured worker is a 57-year-old female who sustained industrial-related injuries on June 30, 2000. She is status post C3-C7 anterior cervical discectomy and fusion. She underwent radiofrequency neurotomy to the right C2 and C3 medial branches and third occipital nerve and radiofrequency neurotomy to the bilateral greater occipital nerves on June 4, 2012. She also underwent right greater occipital nerve radiofrequency ablation on November 26, 2012. On the examination conducted on December 11, 2012 she reported somewhat less relief from her right greater occipital nerve radiofrequency ablation than previously and was frustrated. Visual analogue scale was rated at 6/10. Medications continued included Ativan 1 milligram one tab at night, Fioricet 50-325-40 milligrams 1-2 tablet thrice per day, Soma 350 milligrams one tablet every night, Baclofen 20 milligrams one tablet twice per day, Cymbalta 60 milligrams one tablet four times per day, Fiorinal 50-325-40 milligrams three times per day, and Lorcet 10-650 twice per day. The treatment plan was for a cervical epidural steroid injection. Work status was permanent and stationary. Magnetic resonance imaging scan of the cervical spine without contrast performed in April 10, 2012 revealed the following findings: (a) apparent progressing multifactorial stenosis at C2-C3 level with anterior protrusion and posterolateral buckling of the ligaments. Contact with and mild effacement of the cord for moderate canal stenosis; (b) C3-C7 anterior fusion; (c) the C6-C& level demonstrates posterolateral osteophytes and buckled anterolateral ligaments contacting the cord without effacement. Mild to moderate canal stenosis; and (d) limited visualization of foraminal stenosis due to an element of artifact on the left. Computed tomography scan of the cervical spine with intrathecal contrast performed on March 26, 2013 revealed (a) mild lateral left-sided C7-T1 disc protrusion. This narrows the left lateral recess and may affect the exiting left C8 nerve root, (b) postsurgical changes throughout the cervical spine as described with multilevel anterior fusion, (c) no significant central canal

stenosis, and (d) minimal anterolisthesis T3-T4 noted. Needle electromyography and nerve conduction velocity testing performed on May 16, 2013 revealed findings that is consistent with a bilateral cervical radiculopathy at the C8 level that is chronic and mild/moderate in severity. On January 7, 2014, the injured worker continued to report significantly limited cervical range of motion and occipital pain. She had flare-ups of her right lower cervicalgia, rhomboid/parascapular region and right cervical radicular pain to her 5th digit which limited her activities of daily living and sleep. A request for a new cervical magnetic resonance imaging scan was made to evaluate possible C7-T1 compression consideration. There was decreased relief of spasms with baclofen use. She rated her pain at 7/10. On examination, severe bilateral greater occipital nerve tenderness was noted, right side greater than left. Bilateral upper and lower paracervical tenderness was noted with spasms, right side greater than left. Range of motion was limited. Spurling's maneuver was positive on the right. Muscle strength was decreased in the right upper extremity. The following medications were renewed: Medrol, Soma, Zofran, Skelaxin, Fioricet, and Fiorinal. A magnetic resonance imaging scan of the cervical spine was performed on January 13, 2014 which revealed: (a) extensive cervical fusions, and (b) moderate to severe central canal narrowing at C7-T1 with subluxation and osteophytes noted. The findings revealed evidence of fusion with screws and demonstrated in C3, C4, C6 and C7. Fusion was present between C4, C5 and C6. There was moderate bilateral frontal narrowing at C6-C7 and moderate to severe central canal narrowing at C7-T1. The injured worker underwent cervical epidural steroid injection under fluoroscopy which she tolerated well, as per the operative report dated February 24, 2014. On March 11, 2014, the progress report of the injured worker reported improvement of her neuritis over the last two weeks but still has residual burning pain in the left middle and ring fingers. She stated that her February 24, 2014 cervical injections gave over 50% relief of bilateral upper cervical radicular pain to the shoulder allowing improved activities of daily living including driving and sleep. However, she reported new urinary urgency and frequency. Occipital head pain has been worsening and she requested greater occipital nerve blocks. She rated her pain as 6/10, described it as constant and was aggravated by heat, cold, activity, and walking. On examination, severe bilateral greater occipital nerve tenderness, right side greater than left, was noted. Cervical spine examination revealed mild bilateral upper paracervical tenderness and lower right paracervical tenderness as well as bilateral spasms. Range of motion was limited. Muscle strength was decreased in the right upper extremity. Left hand grip was noted at 4+/5. Sensation to pin prick and light touch was decreased at the left C8. Right triceps reflex was noted 1+. The injured worker was started with Norco 10/325 milligrams tablets 1-2 three times a day, Medrol (pak) 4 milligram tablets, Zofran 4 milligram tablets as needed, Skelaxin 800 milligram tablets as needed, Fioricet 50/325/40 milligram tablets three times a day, Cymbalta 60 milligram tablets as needed, and Fiorinal 50/325/40 milligram capsules as needed. Treatment plan includes proceeding with bilateral occipital nerve block injections to be scheduled in 1-2 weeks. Orders were written for a series of 2-3 injections under fluoroscopic guidance at 1-2 intervals. A urine drug screening test performed on March 11, 2014 revealed positive for barbiturates. On March 13, 2014, utilization review non-certified requests for Zofran and Fioricet. Cymbalta was certified. Cervical epidural steroid injection at C7-T1 to include anesthesia, radiology, fluoroscopic guidance, right C2-3, C3-4 medial branch block to include anesthesia, radiology, fluoroscopic guidance and bilateral greater occipital nerve to include anesthesia, radiology and fluoroscopic guidance were non-certified. It was noted that the treating physician has not documented associated reduction in pain medication use from the most recent epidural steroid injection in February 2014 and the

injured worker had undergone right C2-C3 medial branch blocks on June 4, 2012 and repeat injections would not be supported. It was also noted the treating physician did not document prior benefit from bilateral greater occipital nerve blocks. As per the injured worker's April 22, 2014 follow-up evaluation and treatment, she complained of dysesthetic left C7-C8 radicular pain and worsening headaches limiting her activities of daily living and sleep. Pain was rated at 9/10, described it as constant, and was aggravated with heat, cold and activity. She also complained of gastrointestinal events. General neurologic examination findings revealed severe bilateral greater occipital nerve tenderness, right side greater than left. Cervical spine examination revealed healed fusion incision. Tenderness was noted at the C2-C3 and bilateral upper paracervical tenderness, right side greater than left. Spurling's maneuver was positive bilaterally. Range of motion was limited. Left hand grip was 4+/5. Sensation to pinprick was decreased on the left C8 dermatome, as well as decreased light touch sensation on the left upper extremity. Right triceps reflex was 1+. The plan was to proceed with cervical epidural steroid injections to be scheduled in 1-2 weeks as well as right occipital nerve block injections. Orders were written for a series of two-to-three injections under fluoroscopic guidance. Opioid contract was renewed. In the follow-up examination on June 24, 2014, she reported only partially responsive to conservative treatment. Her chief complaint was right side upper neck pain and bilateral occipital neuralgia. She also complained of gastrointestinal distress with ibuprofen. She rated her pain at 8/10 and pain was aggravated with heat, cold, activity, sitting, and walking. General neurologic examination revealed severe bilateral greater occipital nerve tenderness, right side greater than left. Cervical spine examination revealed tenderness was noted over the C2-C3 and bilateral upper paracervical muscles, right side greater than left, with spasms. Range of motion was limited. Spurling's maneuver was positive. Muscle strength was decreased in the bilateral upper extremity. Sensation was decreased in the bilateral C8 while light touch was also decreased in the bilateral upper extremities. Bilateral triceps was noted at 1+. Her latest magnetic resonance imaging showed a five-millimeter C7-T1 anterolisthesis and a three-millimeter C2-C3 disc bulge. She was recommended to proceed with cervical epidural steroid injections to be scheduled in 1-2 weeks, as well as bilateral occipital nerve radiofrequency ablation. Orders were written in a series of two to three injections under fluoroscopic guidance (if indicated) at 1-2 weeks intervals. A urine drug screening test collected on June 24, 2014 revealed that she was positive for barbiturates and negative for illicit drugs. She was diagnosed with (a) cervical spinal stenosis, (b) neck sprain and strain, (c) failed neck surgery syndrome, (d) occipital neuralgia, (e) cervical myofascial pain syndrome, (f) cervicogenic headache, (g) cervical facet arthropathy, and (h) cervical radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ativan 1mg #30 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24.

Decision rationale: Ativan (lorazepam) is classified under benzodiazepine drug. According to the California Chronic Pain Medical Treatment Guidelines, this medication is not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit this medication to 4 weeks. Muscle relaxant effects tolerance may occur within weeks. In this injured worker's case and as per medicals, she has been using Ativan since December 2012 or even prior. However, since the injured worker has been taking this medication for quite some time, weaning is recommended. This request is not medically necessary.

Soma 350mg #30 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: The medical records indicate that the injured worker has been using Soma 350 milligrams since 2012 and may be prior to that. According to the California Chronic Pain Medical Treatment guidelines, this medication is not recommended and is not indicated for long-term use. Abuse of this medication has been noted for sedative and relaxant effects and this can augment and alter effects of other drugs. However, since the injured worker has been using this medication for quite some time abrupt discontinuation of this medication is not advised, therefore, weaning should be provided. This request is not medically necessary.

Fiorinal 50/325/40mg #90 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

Decision rationale: Fiorinal is composed of Butalbital, aspirin, and caffeine. This medication, with its specific component Butalbital is generally classified under Barbiturate-containing analgesic agents. According to the California Chronic Pain Medical Treatment Guidelines, this medication is not recommended and there is high potential for drug dependence and no evidence exists to show a clinically important enhancement of analgesic efficacy of Barbiturate-containing analgesic agents due to the barbiturate constituents. There is risk of medication use as well as headache. Continued use is not medically appropriate. However, since this injured worker has been utilizing Fiorinal in the long term because abrupt cessation is not advised thus weaning process should be provided. This request is not medically necessary.

Cervical Epidural injection under anesthesia with fluoroscopic guidance x 2 X-rays x 2:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections. Decision based on Non-MTUS Citation Official Disability Guidelines Lumbar Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: As per medical report dated March 11, 2014 and April 22, 2014, while it is noted that the injured worker reported 50-80% relief following her cervical epidural steroid injection performed in February 24, 2014 which allowed her to increase her activities of daily living including driving and sleep; it should be noted that the injured worker continued to rate her pain at 6-9/10 which showed no significant improvement from her previous pain level ratings. Also, medicals document no significant reduction in pain medication intake. Also, current research does not support series of three injections in either diagnostic or therapeutic phase and it is recommended that no more than two epidural steroid injections are to be provided. Based on this clinical presentation, the medical necessity of the requested cervical epidural injection under anesthesia with fluoroscopic guidance x 2 X-rays is not established. As such, this request is not medically necessary.

Bilateral Occipital RFA under anesthesia with Fluoroscopic guidance X-rays: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck Chapter, Head Chapter.

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: As per December 2012 medicals, the injured worker was frustrated as her previous greater occipital nerve radiofrequency ablation provided somewhat less relief than previously and was frustrated. Her pain using visual analogue scale score was rated at 6/10 and continued with the same medications. While repeat neurotomies may be required, duration for at least 12 weeks at equal to or more than 50% pain relief should be documented. In this injured workers' case, the treating physician did not document any quantitative amount of pain relief and instead the injured worker showed poorer response. Also, this medical treatment is not recommended as a treatment for cervicogenic headaches. In this case, she was diagnosed with both occipital neuralgia and cervicogenic headaches. Therefore, the medical necessity of the requested bilateral occipital radiofrequency ablation under anesthesia with fluoroscopic guidance X-rays is not established.

Medrol Pak 4mg #1 with 1 refill: 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 Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Corticosteroids (oral/parenteral/IM for low back pain).

Decision rationale: Medrol (Pak) is also known as a methylprednisolone which is generally classified as a corticosteroid. Since the California Chronic Pain Medical Treatment Guidelines is silent regarding corticosteroids, the Official Disability Guidelines was consulted. The guideline state that this medication is not recommended for acute non-radicular pain or chronic pain. It further states that treatment in the chronic phase of injury should generally be after a symptom-free period with subsequent exacerbation or when there is evidence of a new injury. In this injured workers' case, she was noted not to be symptom-free after provision of Medrol pak in March 2014 and has no evidence of any new injury. Therefore, the medical necessity of the requested Medrol (pak) 4 milligrams #1 with one refill is not established.

Fioricet 50/325/40mg #210: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

Decision rationale: Fioricet is composed of Butalbital, acetaminophen, and caffeine. This medication, together with Fiorinal has its specific component Butalbital which is generally classified under Barbiturate-containing analgesic agents. According to the California Chronic Pain Medical Treatment Guidelines, this medication is not recommended and there is high potential for drug dependence and that no evidence exists to show a clinically important enhancement of analgesic efficacy of Barbiturate-containing analgesic agents due to the barbiturate constituents. There is risk of medication use as well as headache. Therefore, the medical necessity of this medication is not established.

Skelaxin 800mg #120 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Metaxalone (Skelaxin) Page(s): 61.

Decision rationale: The injured worker is noted to be using Soma (carisoprodol) which is another antispasmodic medication used by the injured worker in the long term. There is no provided overriding rationale or justification that can prove the medical necessity of using two antispasmodics at the same time. Also, this class of medication is noted not to be used in the long term as efficacy decreases and may lead to dependence. Therefore, long term use of Skelaxin is not medically appropriate.

Zofran 40mg #30 with 1 refill: 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 Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Antiemetics (for opioid nausea).

Decision rationale: Zofran (Ondansetron) as per the Official Disability Guidelines Pain Chapter this medication is not recommended for nausea and vomiting secondary to chronic opioid use. As per most recent medicals, although the injured worker is complaining of nausea but denies vomiting she is noted to be no longer under opioid medication. Therefore, the medical necessity of the requested Zofran is not established.