

<b>Case Number:</b>	CM14-0012300		
<b>Date Assigned:</b>	05/30/2014	<b>Date of Injury:</b>	08/05/2002
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	12/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2014

### 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 Internal Medicine 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 54 year old male injured on 08/05/02 due to an undisclosed mechanism of injury. Current diagnoses include chronic pain syndrome, brachial plexus lesions, mononeuritis of unspecified site, osteoarthritis of the shoulder, cervical spondylosis with myelopathy, degenerative cervical intervertebral disc disorder, cervicgia, and other syndromes affecting the cervical region. The clinical note dated 12/10/13 indicates the injured worker presented complaining of cervical pain, upper extremity pain. Physical assessment reveals well-nourished, normal affect and no acute distress. Musculoskeletal examination reveals no changes from previous. Medications include Lyrica, Butrans increased to 10mcg, Lidoderm patch, Cyclobenzaprine, and Protonix. The initial request for one pulsed radiofrequency denervation to the right subscapular nerve, medical clearance to include history and physical, EKG and labs, and refill of Cyclobenzaprine was initially denied on 12/30/13. 3547

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 PULSED RADIOFREQUENCY DENERVATION TO THE RIGHT SUPRASCAPULAR NERVE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 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 (Chronic), Pulsed radiofrequency treatment (PRF).

**Decision rationale:** As noted in the Official Disability Guidelines, pulsed radiofrequency treatment is not recommended. Pulsed radiofrequency treatment (PRF) has been investigated as a potentially less harmful alternative to radiofrequency (RF) thermal neurolytic destruction (thermocoagulation) in the management of certain chronic pain syndromes such as facet joint pain and trigeminal neuralgia. Pulsed radiofrequency treatment is considered investigational/not medically necessary for the treatment of chronic pain syndromes. As such, the request for one pulsed radiofrequency denervation to the right suprascapular nerve cannot be recommended as medically necessary.

**1 MEDICAL CLEARANCE TO INCLUDE HISTORY AND PHYSICAL, EKG AND LABS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 - Lumbar & Thoracic (Acute & Chronic), Preoperative testing, general.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**REFILL OF CYCLOBENZAPRINE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41.

**Decision rationale:** As noted on page 41 of the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the patient has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. Additionally, there is no subsequent documentation regarding the benefits associated with the use of cyclobenzaprine following initiation. As such, the medical necessity of refill of cyclobenzaprine cannot be established at this time.