

<b>Case Number:</b>	CM14-0129024		
<b>Date Assigned:</b>	08/18/2014	<b>Date of Injury:</b>	04/09/2001
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	08/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/13/2014

### 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 & Emergency Medicine and is licensed to practice in Florida. 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 patient is a 48 year-old with a date of injury of 04/09/01. A progress report associated with the request for services, dated 07/18/14, identified subjective complaints of neck and arm pain. Objective findings included tenderness to palpation of the cervical facet joints and painful range of motion. Motor and sensory function was normal. Diagnoses included facet syndrome and neuropathic pain. Treatment had included a cervical fusion and subsequently a cervical neurotomy in December 2013 with 50% pain relief. He has also been on NSAIDs and oral analgesics. A Utilization Review determination was rendered on 08/07/14 recommending non-certification of "Bilateral radiofrequency neurotomy at C3-4 and C7-T1; OxyContin 60mg #120 with 2 refills; Motrin 800mg #90 with 5 refills; and Cymbalta 30mg #30 with 3 refills".

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Bilateral radiofrequency neurotomy at C3-4 and C7-T1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Facet Joint Radiofrequency Neurotomy.

**Decision rationale:** Also called facet rhizotomy, the Medical Treatment Utilization Schedule (MTUS) Guidelines note that radiofrequency neurotomy of facet joint nerves of the cervical spine provides good temporary relief of pain. They further note that facet neurotomies should be performed only after a positive response to a facet injection. The Official Disability Guidelines (ODG) state that studies have not demonstrated improved function. They list the following criteria for use:-Only after a positive diagnostic medial branch block.-Repeat neurotomies should not occur at an interval of less than 6 months from the first procedure.-A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at > 50% relief.-Repeat neurotomies depend on evidence such as improvement in pain, decreased medications, and documented improvement in function.-If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.-There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. In this case, the duration of the pain relief from the previous neurotomy was not specified, nor the specific levels treated on each side, and whether the current request is for the same levels. If not, the result of any diagnostic nerve block on the levels requested. Repeat neurotomies depend on evidence of pain improvement and function. In this case, the patient's pain has worsened to the point of becoming housebound and his level of activity has decreased markedly. Therefore, the record does not document the medical necessity for the cervical radiofrequency ablations.

**OxyContin 60mg #120 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181, Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** OxyContin is an opioid analgesic. The California Medical Treatment Utilization Schedule (MTUS) Guidelines related to on-going treatment of Opioids state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity (Eriksen 2006). The documentation submitted lacked a number of the elements listed above, including the level of functional improvement afforded by the chronic opioid therapy. The Guidelines also state that with chronic low back pain, opioid therapy "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (> 16 weeks), but also appears limited." Additionally, "There is also no evidence that Opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain (Martell - Annals, 2007)." The MTUS further states that Opioids are not recommended for neck complaints for more than 2 weeks. The patient has been on Opioids in excess of 16 weeks. In this case, there is no apparent pain relief with the medication and no documentation of the other elements of the

pain assessment referenced above for necessity of therapy beyond 16 weeks. Therefore, there is no documented medical necessity for OxyContin.

**Motrin 800mg #90 with 5 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen; NSAIDs Page(s): 12; 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Nonprescription Medications.

**Decision rationale:** Motrin is a non-steroidal anti-inflammatory agent (NSAIDs). The Medical Treatment Utilization Schedule (MTUS) states that NSAIDs are recommended for use in osteoarthritis. It is noted that they are: "Recommended at the lowest dose for the shortest period in patients with moderate to severe pain." They further state that there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The Official Disability Guidelines (ODG) state that studies have found that NSAIDs have more side effects than acetaminophen or placebo, but less than muscle relaxants or narcotic analgesics. They further state that nonprescription medications such as acetaminophen and NSAIDs will provide sufficient pain relief for most acute and subacute disorders of the neck. Another study concluded that NSAIDs should be recommended as a treatment option after acetaminophen. The recommendations for the use of NSAIDs for long-term therapy are mixed. In this case, the therapy is long-term and there is no documentation in the record of the benefit of the ongoing therapy including functional improvement. The patient's function has worsened. Therefore, there is no documentation for the medical necessity of Motrin.

**Cymbalta 30mg #30 with 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain; Cymbalta; SNRIs Page(s): 13-16; 42; 105.

**Decision rationale:** Cymbalta (duloxetine) is an SNRI class antidepressant. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines note that some antidepressants are: "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain (Feuerstein, 1977) (Perrot, 2006)." The tricyclic agents are generally considered first-line unless they are ineffective, poorly tolerated or contraindicated. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesics, sleep quality and duration as well as a psychological assessment. The long-term effectiveness of antidepressants has not been established. For neuropathic pain, tricyclics agents are recommended as first-line. Recent reviews also list tricyclics and SNRIs (duloxetine and venlafaxine) as first-line options. The Guidelines note that non-neuropathic pain is generally treated with analgesics and anti-inflammatories. In

this case, the record does not substantiate the impression of neuropathic pain based on signs and symptoms (versus radicular pain). Therefore, the record does not document the medical necessity for Cymbalta.