

Case Number:	CM14-0159856		
Date Assigned:	10/03/2014	Date of Injury:	05/12/2006
Decision Date:	10/30/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	09/29/2014

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 Emergency Medicine and Fellowship Trained in Emergency Medical Services and is licensed to practice in 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 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 62-year-old male who reported an injury on 05/12/2006 due to unspecified cause of injury. The injured worker complained of bilateral leg pain, bilateral arm pain, left lower back pain, left anterolateral thigh, bilateral lower back pain, and bilateral neck pain. The injured worker had diagnoses of neck pain, cervicalgia, cervical postlaminectomy syndrome, postlaminectomy syndrome, cervical region, disorder of the back, and lumbar spondylosis with myelopathy, spondylosis with myelopathy lumbar region, chronic post-traumatic headache, lower back pain and lumbago. The past treatments included medication, epidural steroid injection, medial branch nerve block, radio frequency neurotomy. The medications included Skelaxin, hydrocodone/acetaminophen, and Lyrica. The injured worker reported a pain level of 1-2/10 to the cervical region using the VAS. The physical findings dated 07/15/2014 of the cervical spine revealed a normal alignment with no muscle atrophy. Soft tissue palpation to the right with no tenderness to the scalene muscle, the sternocleidomastoid, the supraclavicular fossa, and the levator scapulae and the rhomboid or tenderness of the paracervicals. Soft tissue palpation on the left revealed no tenderness of the scalene muscle, the sternocleidomastoid, the supraclavicular fossa, and the levator scapulae or the rhomboid. Tenderness of the paracervicals hypertonicity, and the trapezius hypertonicity. Tenderness to palpation at the occipital protuberance, the mastoid process, the spinous process and tenderness of the transverse process right at the L3. Active range of motion revealed pain elicited by motion, painful restricted range of motion, noted increased pain at the axial loading. The motor strength revealed extension 5/5, flexion 5/5, rotation 5/5, and lateral flexion 5/5. The right C5 abduction deltoid 5/5, external rotation infraspinatus 5/5, internal rotation supraspinatus 5/5, left L5 revealed abduction deltoid 5/5, external rotation infraspinatus 5/5, and internal rotation supraspinatus 5/5, right C6 revealed a flexion biceps 5/5, C6 on the left flexion biceps 5/5, C7 on

the right extension triceps 5/5 and flexion wrist 5/5. Left C7 extension triceps 5/5, flexion of wrist 5/5. The neurological system revealed decreased sensation at the C7 and C8 decreased sensation at the 4th and 5th digits. Hoffmann's reflex was absent. The treatment plan included a radio frequency neurotomy. The Request for Authorization form dated 09/25/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency neurotomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): page 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Facet joint radiofrequency neurotomy

Decision rationale: The request for radio frequency neurotomy is not medically necessary. The California MTUS/ACOEM guidelines indicate that radiofrequency neurotomies and facet rhizotomy are optional for chronic regional neck pain as there is limited evidence that they may be effective in relieving or reducing cervical facet joint pain. Official Disability Guidelines indicates that facet joint radiofrequency neurotomies are under study. However, the criteria for use of cervical facet radiofrequency neurotomy include the patient have a diagnosis of facet joint pain which is indicated by subjective unilateral pain that does not radiate past the shoulder and objective findings of axial neck pain with no radiation, tenderness to palpation in the paravertebral area (facet region), decreased range of motion with extension and rotation and the absence of radicular findings and/or neurologic findings. They further indicate that approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function. No more than two joint levels should be injected one time. Additionally, there should be evidence of a formal plan of rehabilitation in addition to facet joint therapy. While repeat neurotomies may be required, they should not be required at an interval of less than 6 months from the first procedure. Duration of effect after the first neurotomy should be documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. The clinical notes indicate the injured worker received a medial branch nerve facet injection on 04/10/2014 that decreased his pain from a 6/10 to 8/10 down to a 1/10 to 2/10 that is immediately after and continues to be a 1/10 to 2/10. The clinical notes indicated that the injured worker's neurological exam revealed decreased sensation of the middle finger at the C7 and C8 decreased sensation to the 4th and 5th digits. Per the guidelines the subjective unilateral pain does not radiate past the shoulders with no radiation tenderness to palpation over the paravertebral area and absence of radicular findings and neurologic findings. The request did not indicate a level or location. As such, the request is not medically necessary.

Ambien CR 12.5mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness and Stress

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

Decision rationale: The request for Ambien CR 12.5 mg #30 is not medically necessary. The Official Disability Guidelines indicate that zolpidem (Ambien) is appropriate for short term treatment of insomnia, generally 2 to 6 weeks. The documentation indicated that the injured worker received a prescription for the Ambien CR 12.5 mg tablets extended release on 03/31/2014 and the clinical notes indicated the injured worker was taking the Ambien CR 12.5 mg on 07/15/2014 clinical notes along with a request for a 30 day refill. The guidelines indicate no greater than 2 to 6 weeks. The request did not indicate a frequency. As such, the request is not medically necessary.

Hydrocodone/APAP 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines.

Decision rationale: The request for hydrocodone/APAP 10/325 mg #120 is not medically necessary. The California MTUS Guidelines recommend hydrocodone/acetaminophen for moderate to moderately severe pain and it indicates that for ongoing management, there should be documentation of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The clinical notes did not indicate the 4 A's as above, as the documentation indicated that the injured worker had a nerve block done and rated his pain 1/10 to 2/10 using the VAS, indicating that the injured worker does not need the hydrocodone/acetaminophen. The request did not indicate a frequency. As such, the request is not medically necessary.