

Case Number:	CM14-0024665		
Date Assigned:	06/11/2014	Date of Injury:	08/22/2005
Decision Date:	07/15/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/26/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, 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 Physician 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 33-year-old female who reported an injury on 08/22/2005. The mechanism of injury was not provided for review. The injured worker ultimately underwent L5-S1 transforaminal lumbar interbody fusion in 06/2012. The injured worker's treatment history included physical therapy, multiple medications, and a radiofrequency ablation to the cervical spine. The injured worker underwent a radiofrequency ablation on 05/24/2013 at the C2, C3, C4, and C5 levels. Following the radiofrequency ablation, the injured worker was evaluated on 06/20/2013. It was noted that the injured worker's medications included Celebrex, Colace, omeprazole, Rybix, and Voltaren. Physical findings included limited range of motion of the cervical spine secondary to pain that radiated into the arm. It was documented that the injured worker had decreased facet tenderness. The injured worker's diagnoses included chronic low back pain, degenerative disc disease, myofascial pain and spasm, neck pain, depression and anxiety, poor sleep hygiene, and GI issues from medications. The injured worker's treatment plan included continuation of medications. The injured worker was evaluated on 05/01/2014. It was documented that the injured worker wanted to consider a RFA. It was noted that the injured worker complained of severe right-sided neck pain. Physical findings included degenerated facet pain of the cervical spine and tenderness to palpation of the paraspinal musculature of the lumbar spine. A request was made for a repeat radiofrequency ablation of the C6, C7, T1, and T2, refill of medications to include Celebrex, Prilosec, Colace, Rybix, OxyContin, Primlev, and an anti-inflammatory topical analgesic dated 06/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

REPEAT RADIOFREQUENCY ABLATION C6, C7, T1: Upheld

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

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 Chapter, Facet joint radiofrequency neurotomy.

Decision rationale: The requested repeat radiofrequency ablation at the C6, C7, and T1 is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not specifically address repeat radiofrequency ablation. The Official Disability Guidelines recommend repeat radiofrequency ablation if there is at least 50% pain relief for 12 weeks or more from the initial procedure. The clinical documentation does indicate that the injured worker underwent a radiofrequency ablation at the requested levels in 03/2013. However, the efficacy of that treatment was not provided within the documentation. Therefore, the appropriateness of an additional radiofrequency ablation at the requested levels cannot be determined. As such, the requested repeat radiofrequency ablation at the C6, C7, and T1 is not medically necessary or appropriate.

CELEBREX 200 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60, 67.

Decision rationale: The requested Celebrex 200 mg #360 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that nonsteroidal anti-inflammatory drugs be used as a first-line medication in the management of chronic pain. However, the California Medical Treatment Utilization Schedule also recommends that medications used in the management of chronic pain be supported by documented functional benefit and a quantitative assessment of pain relief. The clinical documentation submitted for review fails to provide any evidence of functional benefit or pain relief resulting from the use of this medication. Additionally, the request as it is submitted fails to provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Celebrex 200 mg #60 is not medically necessary or appropriate.

VOLTAREN GEL 1% #4 TUBES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines DICLOFENAC/VOLTAREN GEL.

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

Decision rationale: The requested Voltaren gel 1% #4 tubes, is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of nonsteroidal topical analgesics for limited durations of treatment for appropriate joints. The clinical documentation does indicate that the injured worker's main pain generators are the lumbar spine and cervical spine. The California Medical Treatment Utilization Schedule does not recommend the use of nonsteroidal anti-inflammatory drugs as topical agents for spinal pain. Additionally, the clinical documentation does indicate that the injured worker has been on this medication for a duration of longer than 4 weeks. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not provide a frequency of treatment or an appropriate body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Voltaren gel 1% 4 tubes is not medically necessary or appropriate.

ANTINFLAMMATORY CREAM (UNSPECIFIED): Upheld

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

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

Decision rationale: The requested anti-inflammatory cream unspecified is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of nonsteroidal anti-inflammatory drugs as topical analgesics for short durations of treatment for patients who cannot tolerate oral formulations of these medications. However, the request does not provide any information about the medication being provided. Therefore, the appropriateness of the medication itself cannot be determined. As such, the requested anti-inflammatory cream unspecified is not medically necessary or appropriate.

RYBIX (TRAMADOL) ODT #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ULTRAM (TRAMADOL).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid, On-Going Management Page(s): 78.

Decision rationale: The requested Rybix (tramadol) ODT #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional

benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review fails to provide any evidence that the injured worker is monitored for aberrant behavior. Additionally, there is no documentation that the injured worker has any functional benefit or pain relief resulting from the use of this medication. Therefore, continued use would not be supported. As such, the requested Rybix (tramadol) ODT #90 is not medically necessary or appropriate. Furthermore, the request as it is submitted does not adequately address a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined.