

<b>Case Number:</b>	CM14-0196582		
<b>Date Assigned:</b>	12/04/2014	<b>Date of Injury:</b>	09/27/2012
<b>Decision Date:</b>	01/30/2015	<b>UR Denial Date:</b>	11/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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 Family Practice and is licensed to practice in North Carolina. 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 patient is a 51-year-old with a reported date of injury of 09/27/2012. The patient has the diagnoses of cervical disc disease, cervical sprain/strain, upper extremity radiculitis, left shoulder pain with tendinitis and bursitis, bilateral carpal tunnel syndrome, right De Quervain's tenosynovitis, lumbar spine strain/sprain, lumbar radiculopathy and right shoulder strain. An MRI of the lumbar spine dated 08/13/2014 showed L3/4 disc protrusion, L5/S1 disc protrusion and multilevel facet arthropathy. An MRI of the left shoulder dated 07/09/2013 showed calcification of the infraspinatus tendon, mild acromioclavicular degenerative joint disease, tendinitis and bursitis. An MRI of the cervical spine dated 07/09/2013 showed mild disc bulges from C5 to T1. Previous treatment modalities have included L3/4 facet spinal cyst aspiration, right L3/4 cortisone injection, left SI joint cannulation for local anesthetic and steroid as well as the right SI joint and left piriformis muscle. Per the most recent progress notes provided for review from the primary treating physician dated 11/11/2014, the patient had complaints of continued left shoulder pain, an 80% decrease of the sacroiliac and left piriformis pain post injection and weakness and soreness. The physical exam noted tenderness to palpation in the left shoulder with crepitus and positive impingement signs and decreased range of motion. The right wrist had a positive Finkelstein's test, decreased range of motion and tenderness to palpation. The treatment recommendations included home exercise program, home electrical muscle stimulation, bracing, medications and left shoulder and right wrist injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral sacroiliac joint rhizotomy quantity 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

**Decision rationale:** The ACOEM chapter on low back complaints and treatment options states: There is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. Radiofrequency neurotomy otherwise known as facet rhizotomy has mixed support for use of low back pain per the ACOEM. Sacroiliac joint rhizotomy is not specifically mentioned; however, per the progress notes dated 11/11/2014, the patient does not wish to have this procedure. Therefore the request is not medically necessary.

**Left piriformis botox injection quantity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin Page(s): 25-26.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum Toxin Page(s): 25-26.

**Decision rationale:** Not recommended for the following: tension-type headache; migraine headache; fibromyositis; chronic neck pain; myofascial pain syndrome; & trigger point injections. Several recent studies have found no statistical support for the use of Botulinum toxin A (BTXA) for any of the following:- The evidence is mixed for migraine headaches. This RCT found that both botulinum toxin type A (BoNTA) and divalproex sodium (DVPX) significantly reduced disability associated with migraine, and BoNTA had a favorable tolerability profile compared with DVPX. (Blumenfeld, 2008) In this RCT of episodic migraine patients, low-dose injections of BoNTA into the frontal, temporal, and/or glabellar muscle regions were not more effective than placebo. (Saper, 2007) Botulinum neurotoxin is probably ineffective in episodic migraine and chronic tension-type headache (Level B). (Naumann, 2008)- Myofascial analgesic pain relief as compared to saline. (Qerama, 2006)- Use as a specific treatment for myofascial cervical pain as compared to saline. (Ojala, 2006) (Ferrante, 2005) (Wheeler, 1998)- Injection in myofascial trigger points as compared to dry needling or local anesthetic injections. (Kamanli, 2005) (Graboski, 2005). Recent systematic reviews have stated that current evidence does not support the use of BTX-A trigger point injections for myofascial pain. (Ho, 2006) Or for mechanical neck disease (as compared to saline). (Peloso-Cochrane, 2006) A recent study that has found statistical improvement with the use of BTX-A compared to saline. Study patients had at least 10 trigger points and no patient in the study was allowed to take an opioid in the 4 weeks prior to treatment. (Gobel, 2006) Recommended: cervical dystonia, a condition that is not

generally related to workers' compensation injuries (also known as spasmodic torticollis), and is characterized as a movement disorder of the nuchal muscles, characterized by tremor or by tonic posturing of the head in a rotated, twisted, or abnormally flexed or extended position or some combination of these positions. When treated with BTX-B, high antigenicity limits long-term efficacy. Botulinum toxin A injections provide more objective and subjective benefit than trihexyphenidyl or other anticholinergic drugs to patients with cervical dystonia. Recommended: chronic low back pain, if a favorable initial response predicts subsequent responsiveness, as an option in conjunction with a functional restoration program. Some additional new data suggests that it may be effective for low back pain. (Jabbari, 2006) (Ney, 2006) Botulinum neurotoxin may be considered for low back pain (Level C). (Naumann, 2008) The requested medication is usually only indicated in the treatment of cervical dystonia. It does not have the indication for trigger point injection in the piriformis muscle. In addition, the most recent progress notes dated 11/11/14 indicate the patient does not want to have this injection. Therefore the request is not medically necessary.

**Urine drug screen quantity 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioid Page(s): 76-84.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication 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. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation

with regard to nonopioid means of paincontrol.(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse.The California MTUS does recommend urine drug screens as part of the criteria for ongoing use of opioids when there are issues of abuse, addiction or poor pain control. There are no indications of any of these issues in the progress reports provided. The current medications listed per the most recent progress notes dated 11/11/2014, indicate the patient is not on any opioid therapy. There is also no reported aberrant behavior that would suggest outside drug use. Therefore the medical necessity for this testing has not been established and the request is not medically necessary.

**Hot/cold unit with pad (days) quantity 30.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** The ACOEM chapter on low back complaints and recommended treatment options states:Physical Therapeutic InterventionsAdjustment or modification of workstation, job tasks, or work hours and methodsStretchingSpecific low back exercises for range of motion and strengtheningAt-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or coldRelaxation techniquesAerobic exercise1-2 visits for education, counseling, and evaluation of home exercise for range of motion and strengtheningThe application of cold and heat in the treatment of low back pain is recommended per the ACOEM. However, it is not established in the provided progress notes why the patient would require a specialized unit for this versus traditional heat or cold applications. Therefore the request is not medically necessary.