

<b>Case Number:</b>	CM15-0167889		
<b>Date Assigned:</b>	09/08/2015	<b>Date of Injury:</b>	05/26/2010
<b>Decision Date:</b>	10/26/2015	<b>UR Denial Date:</b>	08/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 injured worker is a 45-year-old female, who sustained an industrial injury on 05-26-2010. The injured worker was diagnosed as having multilevel disc disease of the cervical spine with mild spinal stenosis at C4-C5 and moderate spinal stenosis at C5-C6, chronic lumbar strain-rule out disc herniation, bilateral knee strain, bilateral shoulder strain, bilateral arm overuse syndrome and depression and anxiety. On medical records dated 07-20-2015 and 06-02-2015, the subjective findings noted cervical spine, thoracic spine, lumbar spine and right wrist pain. Neck pain was noted to radiate to upper extremities while low back pain radiates to lower extremities. Right wrist pain was associated with weakness and numbness was noted. Pain was noted as 8-9 out of 10. Objective findings were noted as cervical and lumbar spine as loss of range of motion. Cervical compression test was positive on the left with radiation of the pain to the left upper extremity with palpable muscular hypertonicity and tenderness. A decreased sensation of the left anterior lateral arm was noted as well. Lumbar spine straight leg rest was positive on the right. In addition, palpable muscular hypotonicity and tenderness was noted, with a decreased sensation on the right anterior lateral leg. The injured worker was noted as not working. The injured worker underwent laboratory studies. Treatments to date included medication. The injured worker was noted to be on Norco since at least 01-30-2015. Current medication included Norco and Lyrica. There were two Utilization Review (UR) dated 08-05-2015. The UR submitted for this medical review indicated that the request for Norco 10-325 mg #80 was modified, Voltaren Gel 1% was non-certified, cervical epidural injections at C5-C6 was non-certified, MRI of cervical spine was non-certified and MRI of lumbar spine was non-certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #80:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. The MTUS states that opioids may be continued: (a) If the patient has returned to work, or (b) If the patient has improved functioning and pain. There is no documentation that the patient fits either of these criteria. Norco 10/325mg #80 is not medically necessary.

**Voltaren gel 1%, #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**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), Voltaren Gel (diclofenac).

**Decision rationale:** According to the Official Disability Guidelines, Voltaren gel is not recommended as a first as a first-line treatment, and is recommended only for osteoarthritis after failure of oral NSAIDs, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. A large systematic review of available evidence on NSAIDs confirms that diclofenac, a widely used NSAID, poses an equivalent risk of cardiovascular events to patients, as did rofecoxib (Vioxx), which was taken off the market. According to the authors, this is a significant issue and doctors should avoid diclofenac because it increases the risk by about 40%. Voltaren gel 1%, #1 is not medically necessary.

**Cervical epidural injection at C5-C6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The MTUS states that cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. There is no documentation that the patient is either a candidate for surgery or and is currently being considered for a cervical procedure. Cervical epidural injection at C5-C6 is not medically necessary.

**MRI (Magnetic Resonance Imaging) of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The MTUS states that an MRI or CT is recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. In addition, the ACOEM Guidelines state the following criteria for ordering imaging studies: 1. Emergence of a red flag, 2. Physiologic evidence of tissue insult or neurologic dysfunction, 3. Failure to progress in a strengthening program intended to avoid surgery, 4. Clarification of the anatomy prior to an invasive procedure. There is no documentation of any of the above criteria supporting a recommendation of a cervical MRI. MRI (Magnetic Resonance Imaging) of the cervical spine is not medically necessary.

**MRI (Magnetic Resonance Imaging) of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The MTUS states that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. The medical record fails to document sufficient findings indicative of nerve root compromise, which would warrant an MRI of the lumbar spine. MRI (Magnetic Resonance Imaging) of the lumbar spine is not medically necessary.