

<b>Case Number:</b>	CM15-0082933		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	09/15/2005
<b>Decision Date:</b>	06/04/2015	<b>UR Denial Date:</b>	04/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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: Physical Medicine & Rehabilitation, Pain Management

### 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 58-year-old male, who sustained an industrial injury on 9/15/05. The injured worker has complaints of neck and right shoulder pain. The diagnoses have included cervicgia, right shoulder issue and residual cervical radiculopathy; history of right cervical radiculopathy with multilevel cervical disc disease; status post anterior cervical discectomy and fusion; degenerative osteoarthritis, knees, bilateral; status post total knee arthroplasty, right knee and history of sprain, left ankle. Treatment to date has included cervical spine magnetic resonance imaging (MRI) noted to be abnormal; epidural steroid injections resulted in temporary relief; right shoulder magnetic resonance imaging (MRI) showed a rotator cuff tear; magnetic resonance imaging (MRI) of the right and left knee; fusion on the cervical spine; arthroscopic surgery of the left and right knee; total knee replacement of the right knee; electromyography/ nerve conduction study and cervical collar. The request was for unknown radiofrequency ablation of the facet joint on the left hand side and tramadol 50mg extended release quantity 120 with one refill.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Radiofrequency Ablation of the Facet Joint on the Left Hand Side: Upheld**

**Claims Administrator 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, Neck and Upper Back (Acute and Chronic), Criteria for use of cervical facet radiofrequency neurotomy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, Facet Joint Diagnostic Blocks, Facet Joint Pain, Signs & Symptoms, Facet Joint Radiofrequency Neurotomy.

**Decision rationale:** Regarding the request for radiofrequency ablation, Occupational Medicine Practice Guidelines state that there is limited evidence the radiofrequency neurotomy may be effective in relieving or reducing cervical facet joint pain among patients who had a positive response to facet injections. ODG recommends diagnostic injections prior to consideration of facet neurotomy. The criteria for the use of radiofrequency ablation includes one set of diagnostic medial branch blocks with a response of greater than or equal to 70%, limited to patients with cervical pain that is non-radicular, and documentation of failed conservative treatment including home exercise, PT, and NSAIDs. Guidelines also recommend against performing medial branch blocks or facet neurotomy at a previously fused level. Within the documentation available for review, the patient has had a medial branch blocks at the left C2 and C3 level on 12/3/2014 without greater than or equal to 70% reduction in pain. Additionally, there is no clear indication that the patient has failed conservative treatment. In the absence of such documentation, the currently requested radiofrequency ablation is not medically necessary.

**Tramadol 50mg ER #120 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Medication Page(s): 75-80.

**Decision rationale:** Regarding the request for Tramadol, Chronic Pain Medical Treatment Guidelines state that Tramadol is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, the patient has ongoing use of Tramadol, without clear indication that the medication is improving the patient's function and pain. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Tramadol is not medically necessary.

