

<b>Case Number:</b>	CM14-0186021		
<b>Date Assigned:</b>	11/13/2014	<b>Date of Injury:</b>	06/01/2007
<b>Decision Date:</b>	12/16/2014	<b>UR Denial Date:</b>	10/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2014

### 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 Physical Medicine and 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 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:

This 59 year-old patient sustained an injury on 6/1/07 while employed by [REDACTED]. Request(s) under consideration include cervical epidural injection at C6-C7, Voltaren 1% gel #1 with 1 refill, and Trazodone 50mg #30 with 2 refills. Diagnoses include cervical radiculopathy/ facet syndrome post-cervical laminectomy syndrome. Conservative care has included medications, therapy, injections, and modified activities/rest. Report of 10/15/14 from the provider noted the patient with chronic ongoing neck pain rated at 5/10 without and 3/10 with medications radiating to shoulders; good quality of sleep and ongoing constipation. Exam showed cervical spine and right shoulder with restricted range of motion; spasm, tenderness, hypertonicity and trigger points at paravertebral muscles; positive Spurling's with radiating down right upper extremity; right shoulder with positive Hawkin's, Neer's, crossover, and empty can testing. The request(s) for Cervical epidural injection at C6-C7, Voltaren 1% gel #1 with 1 refill, and Trazodone 50mg #30 with 2 refills were non-certified on 10/31/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical epidural injection at C6-C7:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection (ESIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 47.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not clearly established here. Submitted reports have not adequately demonstrated any progressive neurological deficits or significant findings of radiculopathy collaborated with imaging. The symptom complaints, pain level, clinical findings and pain medication dosing remained unchanged for this chronic 2007 injury. The patient continues to treat for chronic symptoms without report of flare-up, new injury, or acute change in clinical findings or progression in functional status. The Cervical epidural injection C6-C7 is not medically necessary and appropriate.

**Voltaren 1% gel #1 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** Per Guidelines, Voltaren Topical Gel may be recommended as an option in the treatment of osteoarthritis of the joints (elbow, ankle, knee, etc..) for the acute first few weeks; however, it not recommended for long-term use beyond the initial few weeks of treatment. The patient's injury was in 2007. Submitted reports show no significant documented pain relief or functional improvement from treatment already rendered from this topical NSAID. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Recent report noted chronic pain symptoms with unchanged activity level. Clinical exam is without acute changes or report of flare-up for this chronic injury. The Voltaren 1% gel #1 with 1 refill is not medically necessary and appropriate.

**Trazodone 50mg #30 with 2 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for Treatment of Chronic Persistent Pain Page(s): 13-16.

**Decision rationale:** MTUS Medical Treatment Guidelines specifically do not recommend for Trazodone. Tolerance may develop and rebound insomnia has been found even after discontinuation, but may be an option in patients with coexisting depression that is not the case

here. There are no evidence-based studies showing indication or efficacy for treatment of Trazodone in insomnia. Submitted reports have not demonstrated functional benefit derived from the previous treatment rendered for this chronic injury 2007. The Trazodone 50mg #30 with 2 refills is not medically necessary and appropriate.