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| <b>Case Number:</b>   | CM14-0217984 |                              |            |
| <b>Date Assigned:</b> | 01/07/2015   | <b>Date of Injury:</b>       | 11/04/2013 |
| <b>Decision Date:</b> | 03/03/2015   | <b>UR Denial Date:</b>       | 12/24/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/29/2014 |

### 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. 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: Texas, Illinois  
 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 is a 25 year old female who sustained a work related injury on 11/04/2013. The mechanism of injury has not been provided with the clinical documentation submitted for review. Per the periodic report and request for authorization dated 12/12/2014 the injured worker reported decreased activities of daily living due to pain, but improvement with current treatment. She is currently utilizing pool therapy and home exercises. Objective physical examination revealed a slow, guarded gait. She was unable to sit due to muscle spasms in her back. There is thoracic tenderness with deep pressure in the left T6-12 with significant muscle spasm. There is moderate facet tenderness with minimal pressure at Left L4-5 and L5-S1. There is paraspinal muscle spasm described as moderate, and straight leg raise provokes lumbar pain. Hip flexion causes back pain. Diagnoses included cervical myofascial pain syndrome with left sided muscle hypertrophy and radiating paresthesias to the left upper extremity with possible myelopathy, lumbosacral back multilevel annular fissures and mild facet hypertrophy, myofascial pain syndrome, and thoracic spine myofascial pain syndrome, muscle spasm and left lower thoracic sensory radiculopathy. Magnetic resonance imaging (MRI) of the lumbar spine dated 12/03/2013 was read by the evaluating provider as showing 2-3mm posterior disc protrusions with high intensity zone/annular fissures at L4-L5 and L5-S1. There is no visualized nerve root compression or central canal narrowing. The plan of care included medications, continuation of pool therapy and home exercises. On 12/24/2014, Utilization Review non-certified prescriptions for Voltaren gel 4 gm, #1, Flector patch, #30, and Kinesio tape and modified a prescription for Xartemis oxycodone apap 7.5/325mg ER #80, based on lack of documented functional

improvement, lack of documented prior treatment with oral NSAIDs and lack of medical necessity. The CA MTUS Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines were cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Xartemis oxycodone apap extended release 7.5/325mg, qty 80: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81.

**Decision rationale:** The injured worker sustained a work related injury on 11/04/2013. The medical records provided indicate the diagnosis of cervical myofascial pain syndrome with left sided muscle hypertrophy and radiating paresthesias to the left upper extremity with possible myelopathy, lumbosacral back multilevel annual fissures and mild facet hypertrophy, myofascial pain syndrome, and thoracic spine myofascial pain syndrome, muscle spasm and left lower thoracic sensory radiculopathy. Treatments have included Gabapentin, Oxycodone, Sonata, Cyclobenzaprine, Tramadol, Flector patch, prednisone, Tramadol. The medical records provided for review do not indicate a medical necessity for Xartemis oxycodone apap extended release 7.5/325mg, qty 80. The records indicate she has been using opioids for about one year, but has not had appreciable improvement, she is still limited in activities of daily living. The MTUS recommends discontinuing opioids if there is no overall improvement in function, unless there are extenuating circumstances. Furthermore, the MTUS states that most randomized controlled trials for the use of opioids in the treatment of chronic pain have been limited to a short-term period (70 days). Therefore, the requested treatment is not medically necessary and appropriate.

**Voltaren gel 4gm, qty 1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

**Decision rationale:** The injured worker sustained a work related injury on 11/04/2013. The medical records provided indicate the diagnosis of cervical myofascial pain syndrome with left sided muscle hypertrophy and radiating paresthesias to the left upper extremity with possible myelopathy, lumbosacral back multilevel annual fissures and mild facet hypertrophy, myofascial pain syndrome, and thoracic spine myofascial pain syndrome, muscle spasm and left lower thoracic sensory radiculopathy. Treatments have included Gabapentin, Oxycodone, Sonata, Cyclobenzaprine, Tramadol, Flector patch, prednisone, Tramadol. The medical records provided for review do not indicate a medical necessity for Voltaren gel 4gm, qty 1.

**Flector patch, qty 30:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain (Chronic)

**Decision rationale:** The injured worker sustained a work related injury on 11/04/2013. The medical records provided indicate the diagnosis of cervical myofascial pain syndrome with left sided muscle hypertrophy and radiating paresthesias to the left upper extremity with possible myelopathy, lumbosacral back multilevel annual fissures and mild facet hypertrophy, myofascial pain syndrome, and thoracic spine myofascial pain syndrome, muscle spasm and left lower thoracic sensory radiculopathy. Treatments have included Gabapentin, Oxycodone, Sonata, Cyclobenzaprine, Tramadol, Flector patch, prednisone, Tramadol. The medical records provided for review do not indicate a medical necessity for Flector patch, qty 30. The official Disability Guidelines does not recommend Flector patch as a first-line treatment due to the increased risk profile with diclofenac, including topical formulations. This Guideline states that Flector patch is FDA indicated for acute strains, sprains, and contusions, but warned about the potential for elevation in liver function tests, severe hepatic reactions, including liver necrosis, jaundice, fulminant hepatitis with and without jaundice, and liver failure during treatment with all products containing diclofenac.

**Kinesio tape:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck Chapter, Kinesio tape (KT)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic)

**Decision rationale:** The injured worker sustained a work related injury on 11/04/2013. The medical records provided indicate the diagnosis of cervical myofascial pain syndrome with left sided muscle hypertrophy and radiating paresthesias to the left upper extremity with possible myelopathy, lumbosacral back multilevel annual fissures and mild facet hypertrophy, myofascial pain syndrome, and thoracic spine myofascial pain syndrome, muscle spasm and left lower thoracic sensory radiculopathy. Treatments have included Gabapentin, Oxycodone, Sonata, Cyclobenzaprine, Tramadol, Flector patch, prednisone, Tramadol. The medical records provided for review do not indicate a medical necessity for Kinesio tape. The official Disability Guidelines does not recommend Kinesio tape due to paucity of evidence supporting its use. Therefore, the requested treatment is not medically necessary and appropriate.