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| Case Number: | CM13-0008388 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 02/17/1993 |
| Decision Date: | 03/14/2014 | UR Denial Date: | 07/24/2013 |
| Priority: | Standard | Application Received: | 08/06/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice and is licensed to practice in Texas and Mississippi. 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 physician 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 60-year-old female who reported an injury on 02/17/1993. The mechanism of injury involved a slip and fall. The patient is currently diagnosed with cervicalgia, cervical radiculitis, bilateral de Quervain's tenosynovitis, multilevel lumbar spondylosis, facet arthropathy, sacroiliac joint pain, lumbar disc disease, lumbar spinal stenosis, lumbar radiculopathy, L4-5 anterolisthesis, bilateral sacroiliac joint pain, and bilateral knee enthesopathies. The patient was seen by [REDACTED] on 06/20/2013. The patient reported 9/10 lower back pain. Physical examination revealed decreased lumbar range of motion, positive Kemp's and minor sign, 5/5 motor strength in bilateral upper and lower extremities, and pain in a multi dermatomal distribution throughout the bilateral upper and lower extremities. Treatment recommendations included continuation of current medication including Flexeril, Percocet, and compounded topical analgesic cream as well as lumbar epidural injections targeting the L4-5 and L5-S1 levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection , targeting the L4-S and L5-S1 and especially the right Sacroiliac Joint (SI) nerve root: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: The Physician Reviewer's decision rationale: California MTUS Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. As per the documentation submitted, the patient's physical examination on the requesting date did not reveal symptoms of radiculopathy. The patient demonstrated 5/5 motor strength in bilateral lower extremities without any neurological deficit. Furthermore, it is noted that the patient has been seen by pain management specialist for injection therapy. However, documentation of a previous epidural steroid injection with at least 50% pain relief and associated reduction of medication use was not provided. There is no evidence of a recent failure to respond to conservative treatment. Based on the clinical information received, the request is non-certified.

Flexeril 10mg one (1) q6hr # 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. Flexeril should not be used for longer than 2 to 3 weeks. As per the documentation submitted, the patient has continuously utilized this medication. There was no documentation of palpable muscle spasm, spasticity, or muscle tension upon physical examination. As guidelines do not recommend long-term use of this medication, the current request is not medically necessary. Therefore, the request is non-certified.

Tramadol, Flurbiprofen, Cyclobenzaprine- compound topical analgesic cream: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of neuropathic pain upon physical examination. There is also no evidence of a failure to respond to first line oral medication prior to initiation of a topical analgesic. Additionally, California MTUS Guidelines state there is no evidence for the use of

any muscle relaxant as a topical product. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

Lower Extremity Nerve Conduction Study: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: California MTUS Guidelines state electromyography, including H reflex test, may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. There was no documentation of a significant neurological deficit upon physical examination. There is also no evidence of a recent failure to respond to conservative treatment. The medical necessity for the requested procedure has not been established. Therefore, the request is non-certified.