

<b>Case Number:</b>	CM13-0015572		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	07/28/2009
<b>Decision Date:</b>	02/05/2014	<b>UR Denial Date:</b>	08/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/23/2013

### 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 Physical Medicine and Rehabilitation, and Pain Medicine, and is licensed to practice in Ohio and Texas. 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 32-year-old female who reported an injury on 7/28/09. The patient is diagnosed with cervical discogenic disease, cervical disc herniation, cervical facet syndrome, occipital neuralgia, thoracic disc herniation, lumbar discogenic disease, lumbar disc herniation, and lumbar facet syndrome. The patient was seen by [REDACTED] on 7/10/13. She reported severe lower back pain with radiation to the bilateral lower extremities. Physical examination of the cervical spine revealed 40% of normal range of motion, tenderness to palpation, 4/5 motor strength in the bilateral upper extremities, 1+ reflexes, and diminished sensation to pinwheel at C5-6 and C6-7. Treatment recommendations included cervical epidural steroid injections and the continuation of current medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Request for cervical steroid injections / facet injections:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301, Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines.

**Decision rationale:** The California MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of radicular pain when used in conjunction with other rehabilitative efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Patients should prove initially unresponsive to conservative treatment. As per the clinical notes, the patient underwent an MRI of the cervical spine on 9/18/13, which indicated no significant neural foraminal narrowing or spinal canal stenosis at C4-5 or C5-6. Additionally, there is no evidence of a recent failure to respond to conservative treatment, including exercises, physical methods, NSAIDs, and muscle relaxants. Furthermore, facet joint injections are not recommended for patients with radicular pain. The current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

**Thoracic epidural steroid injections/ facet injections:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Pain Medical Treatment Guidelines Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301, Chronic Pain Treatment Guidelines the Chronic Pain Medical Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines.

**Decision rationale:** The California MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of radicular pain when used in conjunction with other rehabilitative efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Patients should prove initially unresponsive to conservative treatment. As per the clinical notes, there is no evidence of a thoracic examination. There is no thoracic spine MRI or electrodiagnostic report submitted for review. There is no evidence of a failure to respond to recent conservative treatment with exercises, physical methods, NSAIDs, and muscle relaxants. Furthermore, facet joint injections are not recommended for patients with radicular pain. Based on the clinical information received, the request is non-certified.

**Sprix nasal spray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Medical Treatment Guidelines Page(s): 67-72.

**Decision rationale:** The California MTUS Guidelines state that NSAIDs are recommended for moderate to severe pain caused by osteoarthritis; they should be used at the lowest dose for the shortest period of time. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. There is no evidence to recommend one drug in this class over another

based on efficacy. As per the clinical notes, the patient has continuously utilized this medication. Despite the ongoing use, the patient continues to report persistent pain. There is no evidence of a failure to respond to first line treatment with acetaminophen as recommended by California MTUS Guidelines. The patient does not maintain a diagnosis of osteoarthritis, either. The medical necessity for a nasal spray as opposed to oral medication has not been established. Based on the clinical information received, the request is non-certified.

**Lidoderm 5% patches:** 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state that topical analgesics are largely experimental in use, with few randomized controlled 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 a failure to respond to oral antidepressants or anticonvulsants prior to the initiation of a topical analgesic. The medical necessity has not been established. Therefore, the request is non-certified.

**Medrol dose pack:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**Decision rationale:** The Official Disability Guidelines state that oral corticosteroids are not recommended for chronic pain. There is no data on the efficacy and/or safety of systemic corticosteroids in chronic pain, and given their serious adverse effects, they should be avoided. Documentation does not identify the patient having an acute exacerbation of symptoms. Therefore, the medical necessity has not been established. As such, the request is non-certified.