MAXIMUS Federal Services

Case Number:	CM13-0033359		
Date Assigned:	12/06/2013	Date of Injury:	09/23/1996
Decision Date:	04/18/2014	UR Denial Date:	09/19/2013
Priority:	Standard	Application Received:	10/09/2013

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 Family Practice 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:

The patient is a 46-year-old male who reported injury on 09/23/1996 due to repetitive stress of the right upper extremity. The patient's treatment history included multiple surgical interventions to the right upper extremity, physical therapy, multiple medications, a TENS unit, and psychological treatment. The patient underwent and electrodiagnostic study in 07/2013 that documented the patient had chronic C7 radiculopathy, improvement in ulnar neuropathy, and no evidence of carpel tunnel syndrome. The patient's most recent clinical evaluation documented that the patient had a positive Tinel's sign bilaterally, decreased deep tendon reflexes in the bilateral upper extremities with significant upper extremity weakness to the right side in both flexion and extension. The patient's medication history included oxycodone, Cymbalta, Ambien, Klonopin, Motrin, Prilosec, Promolaxin, and trazodone. It was noted that the patient would be transitioned off trazodone and prescribed hydroxyzine secondary to significant side effects related to trazodone usage. It was also noted that the patient would be prescribed oxymorphone extended release for baseline pain. The patient's diagnoses included cervicalgia with bilateral radiculopathy, right shoulder arthropathy with neuropathic pain, right carpel tunnel syndrome, status post right ulnar nerve transposition surgery with residual pain, reactive sleep disturbance and reactive depression.

IMR ISSUES, DECISIONS AND RATIONALES

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

NEW MEDICATION: HYDROXYZINE 25MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation PAIN CHAPTER, INSOMNIA TREATMENT

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, INSOMNIA TREATMENTS

Decision rationale: The California Medical Treatment Utilization Schedule does not address insomnia treatments. Official Disability Guidelines recommend psychological intervention for sleep disorders associated with chronic pain. However, clinical documentation submitted for review does indicate that the patient has been using Ambien and trazodone as a sleep aid. It is noted that the patient has had significant side effects related to trazodone usage. However, the efficacy of Ambien is not clearly established. Therefore, it is unclear why an additional sleep aid would be needed. The clinical documentation submitted for review does not provide and adequate assessment of the patient's sleep hygeine to assess the appropriateness of medication usage. Therefore, hydroxyzine 25 mg is not medically necessary or appropriate.

CERVICAL EPIDURAL STEROID INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN GUIDELINES, ,

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

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has undergone a recent course of physical therapy that has failed to provide relief of symptoms. Additionally, the clinical documentation does indicate that the patient has previously undergone electrodiagnostic study that does provide evidence of radiculopathy. However, the patient's most recent clinical evaluation does not provide any physical findings that specifically identify deficits in specific dermatomal distributions. The clinical documentation provides very vague support of radiculopathy. Also, the request as it is written does not clearly identify at what level the cervical epidural steroid injection would be administered to. Therefore, the appropriateness of the request cannot be determined. As such, the requested cervical epidural steroid injection is not medically necessary or appropriate