

Case Number:	CM13-0050719		
Date Assigned:	12/27/2013	Date of Injury:	07/02/2005
Decision Date:	05/22/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/14/2013

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 Internal Medicine 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 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:

This patient is an injured worker with a diagnosis of cervical spine discogenic disease with radiculopathy. The date of injury is 07-02-2005. The patient stated on the date of injury he was working at a cash register when a wooden beam adjacent to where he was standing broke loose and fell on him. He stated he was struck on his face, neck and left shoulder. Patient has received physical therapy, massage, TENS unit, therapeutic exercises, acupuncture for about a month. He received a series of epidural steroid injections in 2005 and 2006 but noted only temporary benefit. Final Medical-Legal Evaluation / Permanent & Stationary Report (1/23/06) had the diagnoses: Status post blunt head injury, Moderate post traumatic cephalgia, C-spine discogenic pain syndrome with left sided radiculopathy, left shoulder impingement syndrome. Positive MRI study, 9/6/05, showing 1-2 mm central disc protrusion at C3-4 with hypertrophic changes; 2 mm central disc protrusion at C5-6 with disc desiccation; 3 mm left lateral disc protrusion at C6-7 with herniation and stenosis. AME diagnoses were: cervical syndrome with radiculopathy, left shoulder sprain, left wrist sprain. Orthopaedic Re-evaluation Report 08-23-2013 by [REDACTED] provided a progress report. Subjective complaint was persistent neck pain. He is taking Tramadol. The patient complained of continuous neck pain that radiates to the shoulders and between the shoulder blades. Pain is relieved by Tramadol. Physical examination: Range of motion of the cervical spine is decreased. There is tenderness and spasm on palpation of the paracervical and trapezius musculature bilaterally and tenderness over the occipital and suboccipital muscles bilaterally. The compression and distraction tests are positive. Diagnoses: (1) cervical strain/sprain exacerbation, (2) cervical spine discogenic disease with radiculopathy. The treatment plan included cervical spine trigger point injection consisting of Depo-Medrol and Xylocaine, prescribed Cyclobenzaprine 10 mg qhs, referral to pain specialist. Agreed Medical Examination (AME) report by [REDACTED] dated 09-19-2007 documented: "With regard to the

cervical spine, the patient has constant slight pain becoming moderate with prolonged posturing of the neck and repetitive flexion and extension." Patient received a series of epidural steroid injections in 2005 and 2006 but noted only temporary benefit. In 2006, patient was released as permanent and stationary. Orthopedic consultation note by [REDACTED] dated 08-01-2012 documented continuous slight to moderate neck pain. Physical therapy, left shoulder steroid injection, ESWT to the left shoulder, and cervical epidural steroid injections. The patient returned to the office on August 23, 2013 and stated that he has not received any further medical attention. On 08-23-2013, patient complained of continuous slight neck pain. [REDACTED] stated: "The patient should be referred to a pain specialist with regard to the cervical spine. No further appointments are scheduled in this office. The patient is capable of performing work with restrictions per P&S report." The utilization review dated 10-29-2013 recommended non-Certification of cervical spine trigger point injection, Cyclobenzaprine, and pain management consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical spine trigger point injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: This patient has a diagnosis of cervical spine discogenic disease with radiculopathy. MRI of cervical spine 09-06-2005 reported disc abnormalities. The California MTUS guidelines state that trigger point injections are not recommended for radicular pain. Therefore, trigger point injections are not recommended for this patient who has been diagnosed with radiculopathy. In addition, the available medical records do not provide documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. The clinical guidelines and medical records do not support the medical necessity of cervical spine trigger point injection. Therefore, the request for cervical spine trigger point injection is not medically necessary.

Cyclobenzaprine 10mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: The patient has chronic conditions, with date of injury 07-02-2005. This is not acute. Cyclobenzaprine is recommended only for acute conditions, not chronic conditions. The patient has been using Tramadol. The addition of Cyclobenzaprine to other agents is not

recommended. Cyclobenzaprine may increase seizure risk in patients taking Tramadol. Therefore, Cyclobenzaprine is not recommended in this patient, who is currently using Tramadol. The clinical guidelines and medical records do not support the medical necessity of Cyclobenzaprine (Flexeril). Therefore, the request for Cyclobenzaprine 10 mg is not medically necessary

Pain management consultation: 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 ACOEM, Chapter 7, page 127.

Decision rationale: American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition (2004) page 127 states "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." The patient described his baseline neck pain as "slight." Previous epidural steroid injections in 2005 and 2006 provided only temporary benefit. The patient's cervical spine has been evaluated by pain management specialist and two orthopedic surgeons in the past. There is agreement on the patient's cervical spine diagnosis. The diagnosis is not uncertain or extremely complex. There is no documentation of psychosocial factors. The condition did not significantly benefit from pain management expertise in the past. The patient describes his baseline neck pain as slight. In the one year period from August 2012 through August 2013, the patient did not receive further medical attention. In August 2013, the orthopedic surgeon did see the need to schedule future orthopedic appointments, and considered the patient permanent and stationary. There was no explanation of how a pain management consultation would benefit the course of care. The clinical guidelines and medical records do not support the medical necessity of pain management consultation. Therefore, the request for pain management consultation is not medically necessary.