

<b>Case Number:</b>	CM13-0066404		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	07/13/2010
<b>Decision Date:</b>	04/15/2014	<b>UR Denial Date:</b>	12/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2013

### 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 Anesthesiology, has a subspecialty in Pain Management 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 an employee of [REDACTED] and has submitted a claim for cervicalgia associated with an industrial injury date of July 13, 2010. Treatment to date has included shoulder surgery, elbow surgery, carpal tunnel release, physical therapy, and medications. A utilization review from December 4, 2013 denied the request for one cervical epidural steroid injection under fluoroscopic guidance, one thoracic epidural steroid injection under fluoroscopic guidance, Lidoderm 5% #90, and Voltaren gel 1%, 5 tubes. Medical records from 2012 to 2014 were reviewed showing the patient complaining of pain in multiple joints which includes the shoulders, neck, upper extremities, and back. The patient has limitations in activities of daily living secondary to pain. An electrodiagnostic report from October 25, 2013 demonstrated possible residual carpal tunnel syndrome and normal nerve conduction at the elbow as well as normal EMG of the right upper extremity and hand. Physical exam demonstrated reduced sensation to light touch along the right arm and right forearm and limited range of motion for the right shoulder. The patient has reached maximum medical improvement at this time.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE CERVICAL EPIDURAL STEROID INJECTION UNDER FLUOROSCOPIC GUIDANCE:** Upheld

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

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

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborated findings of radiculopathy) with no more than one interlaminar level or to nerve root levels using the transforaminal approach should be injected at one session. In this case, progress notes did not document any specific objective evidence of a cervical radiculopathy; the neurological exams in the progress notes did not conclusively suggest a cervical nerve involvement. In addition, electrodiagnostic tests did not find any signs of cervical nerve involvement. This request is also nonspecific in terms of level of injection. The request for one cervical epidural steroid injection under fluoroscopic guidance is not medically necessary and appropriate.

**PRESCRIPTION LIDODERM 5% #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines, Lidoderm may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. In this case, the patient was concurrently prescribed Neurontin, a first-line medication for peripheral pain. However, there had been no discussion concerning the efficacy of this medication when Lidoderm was prescribed presumably for the first time. The request for Lidoderm 5%, #90 is not medically necessary and appropriate.

**PRESCRIPTION VOLTAREN GEL 1%, 5 TUBES:** Upheld

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

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

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines, Voltaren gel is indicated for relief of osteoarthritis pain in the joints that lend themselves to topical treatment which includes the ankles, elbows, feet, hands, knees, and wrist. In this case, the patient has multiple joint pains which may be treated with topical medication such as Voltaren. However, the requested amount of 5 tubes of Voltaren is excessive. Therefore, the request for Voltaren gel 1%, 5 tubes are not medically necessary and appropriate.

