

Case Number:	CM14-0016262		
Date Assigned:	02/21/2014	Date of Injury:	03/10/2009
Decision Date:	07/24/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/10/2014

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 Occupational 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 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 42-year-old female who has filed a claim for upper back pain associated with an industrial injury date of March 10, 2009. Medical records provided for review indicate mid-back pain radiating to the left lateral mid-chest wall (approximately left T6-8 dermatome) with numbness. Findings include antalgic gait; tenderness over the T8 region; decreased cervical range of motion due to pain; decreased sensation in the right upper extremity in a non-specific pattern, and in the left T6-8 dermatomes. Electrodiagnostic study of the upper extremities dated March 01, 2013 was normal. An MRI of the thoracic spine dated July 18, 2011 showed mild loss of disc height with prominent endplate osteophyte at T6-7 and T9-10; minimal disc bulges at T7-8 and T8-9; and patent central canal and foramen throughout the thoracic spine. Treatment to date has included opioids, muscle relaxants, Ambien, and thoracic epidural steroid injections. A utilization review from January 28, 2014 denied the requests for thoracic epidural injection under fluoroscopy T5-T6 as the documentation does not provide evidence of radiculopathy on imaging or electrodiagnostic testing; thoracic intercostal nerve root blocks under fluoroscopy T6-8 as there was no documentation of failure of conservative care for intercostal neuralgia; Flexeril 10mg #90 as there is no documentation that this medication is being prescribed for short-term treatment; and Ambien 12.5mg CR #30 as there was no documentation of short-term use.

IMR ISSUES, DECISIONS AND RATIONALES

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

THORACIC EPIDURAL INJECTION UNDER FLUOROSCOPY T5-T6 QTY: 1.00:
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 : Epidural steroid injections (ESIs) page 46 Page(s): 46.

Decision rationale: As noted on page 46 of the MTUS Chronic Pain Guidelines, epidural steroid injections are recommended in patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Furthermore, repeat blocks should only be offered if at least 50% pain relief with associated reduction of medication use for six to eight weeks was observed following previous injection. This patient has had several thoracic epidural steroid injections in the past, with the fourth one providing only limited relief. There is no documentation regarding failure of conservative management, and the latest thoracic epidural steroid injection did not provide significant pain relief. Therefore, the request for left thoracic epidural steroid injection under fluoroscopy T5-6 is not medically necessary.

THORACIC INTERCOSTAL NERVE ROOT BLOCKS UNDER FLUOROSCOPY T6-T8 QTY: 1.00: 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) Neck and Upper Back chapter, Discectomy-laminectomy-laminoplasty.

Decision rationale: According to the ODG, confirmatory selective nerve root blocks may be used in patients with abnormal imaging studies without evidence of sensory, motor, reflex, or EMG changes. The block should provide pain in the abnormal nerve root, and provide at least 75% pain relief for the duration of the local anesthetic. In this case, there are no imaging or electrodiagnostic results consistent with nerve root involvement, and the indication for nerve root block has not been met. Therefore, the request for left thoracic intercostal nerve root blocks under fluoroscopy T6-8 is not medically necessary.

FLEXERIL 10MG; QUANTITY 90: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines state that cyclobenzaprine is a skeletal muscle relaxant and a CNS depressant that is recommended as a short-course therapy. The effect

is greatest in the first 4 days of treatment. There is no documentation as to whether this patient has been on this medication. However, the limited documentation does not indicate acute exacerbation of pain or presence of muscle spasms to support this request. Therefore, the request for Flexeril 10mg #90 is not medically necessary.

AMBIEN 12.5MG CR; QUANTITY 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Treatment in Workers Compensation, 5th Edition.

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, Ambien (zolpidem tartrate).

Decision rationale: According to the ODG, zolpidem is approved for the short-term (usually two to six weeks) treatment of insomnia. There is no documentation as to whether this patient has been on this medication. In this case, there is no documentation regarding sleep issues in this patient to support this request. Therefore, the request for Ambien 12.5mg CR #30 is not medically necessary.