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| Case Number: | CM14-0131896 | | |
| Date Assigned: | 08/20/2014 | Date of Injury: | 09/21/2004 |
| Decision Date: | 09/23/2014 | UR Denial Date: | 07/29/2014 |
| Priority: | Standard | Application Received: | 08/18/2014 |

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas & Oklahoma. 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 injured worker is a 56-year-old male with a reported date of injury on 09/21/2004. The mechanism of injury was not submitted within the medical records. His diagnoses were noted to include cervical discopathy to C5-6 and significant shoulder impingement. His previous treatments were noted to include shoulder injections and medications. The progress note dated 07/02/2014 revealed complaints of pain to the right shoulder. The injured worker reported the injection that was administered to the right shoulder did help, but after 2 weeks, the pain had returned. The injured worker complained of neck pain, rated 9/10, with radiation to the bilateral upper extremities. The injured worker complained of pain to the shoulder and arm, rated 8/10 to 10/10. The physical examination of the cervical spine revealed tenderness at the occipital insertion of the paracervical musculature with mild tenderness bilaterally in the trapezii. The midline base of the cervical spine was tender. There was decreased range of motion and scapula retraction was limited and produced rhomboid pain. The deep tendon reflexes were intact and the sensation was intact to all upper extremities with a mild inhibition by neck pain, but no gross weakness. The injured worker had mildly positive head compression sign, but the Spurling's maneuver was normal. The physical examination of the bilateral shoulder noted tenderness in the sternoclavicular joint, anterior capsule, and acromioclavicular joint. The range of motion to the bilateral shoulders was diminished and crepitus on motion was present. There were positive Neer's and Hawkins maneuvers and impingement signs. The O'Brien's and drop arm test were negative. The motor function test was rated 4/5 and the sensation examination was normal in the upper extremities. The deep tendon reflexes were equal bilaterally. The provider indicated the injured worker had had MRIs to the bilateral shoulders. The Request for Authorization form dated 07/02/2014 was for pain management consultation for consideration of cervical epidural

steroid injections. The Request for Authorization form for transdermal creams (unspecified) and the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management Consultation for consideration of Cervical Epidural Steroid Injections:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injections, Page(s): 46. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM 2nd Edition American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition (2004), Chapter 6, page 163.

Decision rationale: The request for a Pain Management Consultation for consideration of Cervical Epidural Steroid Injections is not medically necessary. The injured worker complained of shoulder pain and neck pain that radiated to the bilateral upper extremities. The CA MTUS/ACOEM guidelines state that if a diagnosis is uncertain or complex, if psychosocial factors are present, or if the plan or course of care may benefit from additional expertise, the occupational health physician may refer a patient to other specialists for an independent medical assessment. A consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or examinee's fitness for return to work. A consultant is usually requested to act in advisory capacity that may sometimes take full responsibility for investigating and/or treating an injured worker with the doctor/patient relationship. The California Chronic Pain Medical Treatment Guidelines recommend epidural steroid injections as an option for treatment of radicular pain. The guidelines criteria for the use of epidural steroid injections is radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The injured worker must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). The injections should be performed using fluoroscopy for guidance. If used for diagnostic purposes, a maximum of 2 injections should be performed. A second block is not recommended if there is an adequate response to first block. Diagnostic blocks should be at an interval of at least 1 to 2 weeks between injections. There should be no more than 2 nerve root levels injected using transforaminal blocks and no more than 1 interlaminar level should be injected at 1 session. There is a lack of documentation with clinical findings consistent with radiculopathy or decreased motor strength or sensation in a specific dermatomal distribution. There is a lack of documentation regarding an MRI to corroborate the cervical radiculopathy symptoms. Therefore, due to the lack of documentation regarding cervical radiculopathy and corroboration with an MRI, a cervical epidural steroid injection is not appropriate, and therefore a pain management consultation is not medically necessary. As such, the request is not medically necessary.

Transdermal creams (unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The request for Transdermal creams (unspecified) is not medically necessary. The injured worker has been utilizing transdermal creams since at least 03/2014. The California Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines primarily recommended topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The request failed to provide the components of the topical analgesic to make a determination. Therefore, due to the lack of components of the transdermal cream, the request is not medically necessary.