

Case Number:	CM14-0020809		
Date Assigned:	04/30/2014	Date of Injury:	03/11/2011
Decision Date:	07/08/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/19/2014

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 and Rehabilitation, 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 56 year old female who was injured on 03/11/2011. She was moving a surgery bed when the bed fell apart. She thought the bed was going to fall on her toe so she grabbed it and it pulled her upper back. Prior treatment history has included 12 physical therapy sessions and ibuprofen; acupuncture, TENS and Terocin; atenolol, omeprazole, Zolpidem, and Lido-capsaicin-Men-Methy-Sal. MRI of the thoracic dated 08/16/2012 revealed degenerative disc disease is seen at T6-T7 through T9-10. There is mild right T2-3 foraminal stenosis but it is stable. She has multilevel dextroscoliosis and multilevel degenerative facet disease. EMG performed on 08/08/2012 is normal. Progress note dated 03/21/2014 (which is the same as exam dated 01/09/2014) states the patient complains of upper back pain which she describes as stabbing and burning with bilateral upper extremity numbness and tingling, right greater than left. She rates her pain as 6/10 without medications and 4-5/10 with pain medications. On examination of the cervical spine, the patient has 5-/5 bilateral upper extremity strength secondary to pain. Her sensation is decreased in C7-8 dermatome. Deep tendon reflexes are 2+ and symmetric. There is tenderness over the cervical paraspinals, traps, and rhomboids; significant muscle spasms with related myofascial restrictions appreciated, right greater than left. Trigger point tenderness is noted in the bilateral traps at C6 to T7 bilaterally. Impressions are thoracic back pain, degenerative disc disease, dextroscoliosis of the thoracic spine, thoracic facet arthropathy, and thoracic spine. It is felt the patient would benefit from a thoracic epidural steroid injection for pain relief, decreased muscle tightness, and improved functional mobility. She is instructed to continue Flexeril at night to help with sleep and to decrease acute flare-up pain and muscle spasms. Prior UR dated 01/17/2014 states the request for thoracic epidural steroid injection under fluoroscopy is non-certified as there is no documented radiculopathy. Flexeril 5 mg #20 is partially certified for Flexeril 5 mg #20 with no refills to allow for titration.

IMR ISSUES, DECISIONS AND RATIONALES

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

THORACIC EPIDURAL STEROID INJECTION UNDER FLUOROSCOPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESIs).

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

Decision rationale: The MTUS Chronic Pain treatment guidelines indicate the purpose of ESI's is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Per MTUS Criteria for ESI, radiculopathy must be documented by physical exam and corroborated by Imaging / Electrodiagnostic studies, and initially unresponsive to conservative management. However, the medical records show no evidence of radiculopathy in a thoracic spinal nerve distribution. Furthermore, there is no Imaging / Electrodiagnostic evidence of a nerve root compression. Therefore, the medical necessity of the requested service cannot be established and is non-certified.

FLEXERIL 5MG #30 WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Cyclobenzaprine (Flexeril) Page(s): 63-64 41-42.

Decision rationale: According to the MTUS guidelines, Flexeril is recommended as an option, using a short course and mixed evidence does not allow for chronic use. The medical records demonstrate that the patient has been on Flexeril, but there is little to no evidence of long term benefit on muscle spasm or functional improvement. Chronic use of muscle relaxants is not recommended by the guidelines. Therefore, the medical necessity for Flexeril is not established, and is partially certified for slow weaning with no refill; 5 mg #15, with no refill.

