MAXIMUS Federal Services

| Case Number: | CM14-0062241 | | |
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| Date Assigned: | 07/11/2014 | Date of Injury: | 03/04/2010 |
| Decision Date: | 08/26/2014 | UR Denial Date: | 04/23/2014 |
| Priority: | Standard | Application Received: | 05/05/2014 |

## 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 Anesthesiology, has a subspecialty in Pain 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:

According to the records made available for review, this is a 45-year-old male with a 3/4/10 date of injury. At the time (4/9/14) of request for authorization for OXY IR 15mg # 65 and Cervical epidural injection (level (s) unspecified), there is documentation of subjective (5-9/10 shoulder pain and back pain) and objective (not specified) findings, imaging findings (cervical spine MRI (1/14/14) report revealed C5-6 mild central canal stenosis and cord compression with moderate left lateral recess/foraminal stenosis, C6-7 marked right lateral recess/foraminal stenosis, mild central canal stenosis and moderate left foraminal stenosis, and C4-5 mild central stenosis and slight cord compression with mild bilateral foraminal narrowing), current diagnoses (chronic pain multiple sites and cervical radiculopathy), and treatment to date (H-wave, TENS unit, medications (including ongoing treatment with oxycodone with improvement in pain), and activity modifications). Regarding OXY IR 15mg # 65, there is no documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, that prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of oxycontin use to date. Regarding Cervical epidural injection (level (s) unspecified), there is no documentation of subjective and objective radicular findings in each of the requested nerve root distributions, imaging findings at each of the requested levels, and failure of additional conservative care .

## IMR ISSUES, DECISIONS AND RATIONALES

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

**OXY IR 15mg # 65:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Oxycodone Page(s): 74-80, 92.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of Oxycontin. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of Oxycontin. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic pain multiple sites and cervical radiculopathy. However, there is no documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. In addition, there is no documentation that prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Furthermore, despite documentation that oxycontin helps pain, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of oxycontin use to date. Therefore, based on guidelines and a review of the evidence, the request for OXY IR 15mg # 65 is not medically necessary.

**Cervical epidural injection (level (s) unspecified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Epidural Steroid Injections (ESIs).

**Decision rationale:** MTUS reference to ACOEM guidelines identifies cervical epidural corticosteroid injections should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of

medications or medical services. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities), as criteria necessary to support the medical necessity of cervical epidural injection. Within the medical information available for review, there is documentation of diagnoses of chronic pain multiple sites and cervical radiculopathy. In addition, there is documentation of subjective (5-9/10 shoulder pain and back pain), imaging findings (cervical spine MRI identifying C5-6 mild central canal stenosis and cord compression with moderate left lateral recess/foraminal stenosis, C6-7 marked right lateral recess/foraminal stenosis, mild central canal stenosis and moderate left foraminal stenosis, and C4-5 mild central stenosis and slight cord compression with mild bilateral foraminal narrowing), and failure of conservative treatment (medications and activity modifications). However, given no documentation of the specific level(s) to be addressed, there is no documentation of subjective (pain, numbness, or tingling) and objective (sensory changes, motor changes, or reflex changes) radicular findings in each of the requested nerve root distributions, imaging (MRI) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels. In addition, there is no documentation of failure of additional conservative care (physical modalities). Therefore, based on guidelines and a review of the evidence, the request for Cervical epidural injection (level (s) unspecified) is not medically necessary.