

Case Number:	CM14-0077838		
Date Assigned:	07/18/2014	Date of Injury:	06/05/2007
Decision Date:	08/18/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/26/2014

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 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:

According to the records made available for review, this is a 56-year-old male with a 6/5/07 date of injury and status post anterior and posterior cervical decompression and fusion at C4-C7 on 9/1/12. At the time (4/7/14) of request for authorization for cervical epidural steroid injection under fluoroscopy C7-T1, Hydrocodone / acetaminophen 7.5 / 300 mg., 1 tablet PO (by mouth), every 3-4 hours prn (as needed) pain Max 2 per day, QTY: 60 zero refills, and Voltaren 1% Gel, use 4 GM. every 6 hours prn (as needed) to affected area of pain, QTY: 5 boxes (3 month supply) zero refills, there is documentation of subjective (neck pain radiating to the right shoulder and scapular edge extending into the triceps and ring and fifth fingers with numbness, tingling and muscle spasms, increased frequency of dropping objects, and associated headaches) and objective (tenderness to palpation over the right cervical paraspinal muscles and facets, painful cervical range of motion, decreased reflexes of the right arm, decreased strength of the right triceps (C7), right interosseous muscles (C7-8), and decreased sensation of the C7 and C8 dermatomes) findings, imaging findings (MRI of the cervical spine (4/19/12) report revealed a 3.1 mm right central disc protrusion which mildly impresses the thecal sac and a high-intensity zone is present within the right posterior annular fibers of the disc which may represent an annular fissure/tear that may be associated with pain at C7-T1), current diagnoses (acquired spondylolisthesis, cervical spinal stenosis, cervical degenerative intervertebral disc, and cervical post-laminectomy syndrome), and treatment to date (medications (Voltaren gel and Hydrocodone/acetaminophen since at least 8/12/13 with decrease in pain levels and increased ability to perform activities of daily living), physical therapy, and activity modification.). In addition, medical report identifies that the patient cannot tolerate oral NSAIDs due to gastritis and GERD. Regarding cervical epidural steroid injection under fluoroscopy C7-T1, there is no documentation of imaging findings (nerve root compression OR moderate or greater central

canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels. Regarding Hydrocodone / acetaminophen 7.5 / 300 mg., 1 tablet PO (by mouth), every 3-4 hours prn (as needed) pain Max 2 per day, QTY: 60 zero refills, there is no 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. Regarding Voltaren 1% Gel, use 4 GM. every 6 hours prn (as needed) to affected area of pain, QTY: 5 boxes (3 month supply) zero refills, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks).

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Epidural Steroid Injection under fuouoscopy C7-T1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 8: Page: 175 Official Disability Guidelines (ODG): Epidural Steroid Injections (ESIs) & Neck & Upper Back Chapter.

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. 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 acquired spondylolisthesis, cervical spinal stenosis, cervical degenerative intervertebral disc, and cervical post-laminectomy syndrome. In addition, there is documentation of subjective (pain, numbness, and tingling) and objective (sensory, motor changes, and reflex changes) radicular findings in each of the requested nerve root distributions, and failure of conservative treatment (activity modification, medications, and physical modalities). However, despite documentation of imaging findings (MRI of the C/S identifying a 3.1 mm right central disc protrusion which mildly impresses the thecal sac and a high-intensity zone is present within the right posterior annular fibers of the disc which may represent an annular fissure/tear that may be associated with pain at C7-T1), there is no documentation of imaging findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested

levels. Therefore, based on guidelines and a review of the evidence, the request for cervical epidural steroid injection under fluoroscopy C7-T1 is not medically necessary.

Hydrocodone / acetaminophen 7.5 / 300 mg., 1 tablet PO (by mouth), every 3-4 hours prn (as needed) pain Max 2 per day, QTY: 60 zero refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s) : 79,80,81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate 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 opioids. 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 acquired spondylolisthesis, cervical spinal stenosis, cervical degenerative intervertebral disc, and cervical post-laminectomy syndrome. In addition, given documentation of ongoing treatment with Hydrocodone/acetaminophen with decrease in pain levels and increased ability to perform activities of daily living, there is documentation of functional benefit or improvement as an increase in activity tolerance as a result of use of Hydrocodone/acetaminophen. However, there is no 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. Therefore, based on guidelines and a review of the evidence, the request for Hydrocodone / acetaminophen 7.5 / 300 mg., 1 tablet PO (by mouth), every 3-4 hours prn (as needed) pain Max 2 per day, QTY: 60 zero refills is not medically necessary.

Voltaren 1% Gel, use 4 GM. every 6 hours prn (as needed) to affected area of pain, QTY: 5 boxes (3 month supply) zero refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac sodium.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to

support the medical necessity of Voltaren Gel 1%. In addition, 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 failure of an oral NSAID or contraindications to oral NSAIDs, as criteria necessary to support the medical necessity of Voltaren Gel. Within the medical information available for review, there is documentation of diagnoses of acquired spondylolisthesis, cervical spinal stenosis, cervical degenerative intervertebral disc, and cervical post-laminectomy syndrome. In addition, given documentation identifies that the patient cannot tolerate oral NSAIDs due to gastritis and GERD, there is documentation of contraindications to oral NSAIDs. Furthermore, given documentation of ongoing treatment with Voltaren gel with decrease in pain levels and increased ability to perform activities of daily living, there is documentation of functional benefit or improvement as an increase in activity tolerance as a result of use of Voltaren gel. However, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). In addition, given documentation of ongoing treatment with Voltaren gel since at least 8/12/13, there is no documentation of short-term use (4-12 weeks). Therefore, based on guidelines and a review of the evidence, the request for Voltaren 1% Gel, use 4 GM. every 6 hours prn (as needed) to affected area of pain, QTY: 5 boxes (3 month supply) zero refills is not medically necessary.