

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0196620 | | |
| Date Assigned: | 12/04/2014 | Date of Injury: | 11/10/2006 |
| Decision Date: | 01/15/2015 | UR Denial Date: | 11/10/2014 |
| Priority: | Standard | Application Received: | 11/24/2014 |

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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:

This is a 54 year old man sustained an industrial injury on 11/10/2006 resulting in injuries to his right shoulder, left hand, and physical/mental being. Treatment has included oral and topical medications and epidural steroid injections. Physician notes from 10/13/2014 state the worker was experiencing increased neck pain with radiation to the shoulder, along the radial aspect of the arm down to the thumb. Cervical range of motion was decreased due to pain. On the following visit, on 11/10/2014, the worker states he is taking his medications regularly and feels that they are working well. There is also mention of lack of energy and strength. On 11/10/2014, Utilization Review evaluated requests for a cervical epidural injection at C7-T1, Fioricet-cod 50-300-40-30mg, and Voltaren gel 1%. The UR physician noted that the worker's complaints did not follow the requirements to allow an epidural injection and past injections did not give the results that would be favorable to repeat the procedure. There is no documentation of any benefit from the worker taking the prescribed medications, no complaints for which Fioricet is typically prescribed, and no specific indication for the topical medication or mechanism for measuring the effects. The requests were denied and subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical epidural injection C7-T1 quantity (QTY) 1.00: 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): 181.

Decision rationale: According to MTUS guidelines, cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. Epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit; however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient recently received cervical epidural injection without documentation of the results of this injection. In his recent request, the provider did not document any signs of radiculopathy at C7-T1 levels of the requested cervical injections. In addition, there is no clinical and objective documentation of radiculopathy. MTUS guidelines do not recommend epidural injections for neck pain without radiculopathy. Therefore, the request for Cervical Epidural Steroid Injection at C7-T1 is not medically necessary.

Fiorcet-cod 50-300-40-30mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

Decision rationale: Fioricet is a Barbiturate-containing analgesic agent (BCA). According to MTUS guidelines: "Barbiturate-containing analgesic agents (BCAs)... [is] not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. (McLean, 2000) There is a risk of medication overuse as well as rebound headache. (Friedman, 1987)." There is no documentation of chronic headaches and no justification for long term use of Fioricet. Therefore, the prescription for Fioricet with Codeine is not medically necessary.

Voltaren Gel 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics ,Nonselective NSAIDS Page(s): 111,107.

Decision rationale: Voltaren Gel (Diclofenac) is a nonsteroidal anti-inflammatory drug (NSAID). According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these

agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Diclofenac is used for osteoarthritis pain of wrist, ankle and elbow; there is no strong evidence for its use for spine pain such as lumbar spine pain and shoulder pain. Therefore, request for Voltaren Gel 1% is not medically necessary.