

<b>Case Number:</b>	CM14-0172355		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	07/10/2013
<b>Decision Date:</b>	11/21/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2014

### 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 Orthopaedic Surgery 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:

This case involves a 61-year-old male service consultant sustained an industrial injury on 7/10/13. Injury occurred when he turned around and hit his forehead on a forklift, lacerating his forehead and pushing his head backwards. Initial treatment included x-rays, wound closure, anti-inflammatory medication, and physical therapy. The patient sustained re-injury on 8/19/13 when the hood of a car dropped on his head at work. Past medical history was positive for Crohn's disease. The 10/7/13 cervical spine MRI impression documented mild to moderate disc degeneration at C3/4 with a disc bulge and protrusion. There was moderate to severe right and mild left foraminal encroachment with potential impingement on the exiting right C4 nerve root. There was a left posterolateral disc protrusion at C4/5 with moderate left foraminal encroachment. There was a left posterolateral disc protrusion at C5/6 with mild bilateral foraminal encroachment. There was mild to moderate bilateral C6/7 foraminal encroachment with severe disc degeneration and bilateral disc osteophytes. Record review available from 11/19/13 to 3/18/14 documented a diagnosis of cervical radiculopathy, cervical spondylosis, and C3/4 disc herniation. Treatment recommendations included physical therapy, acupuncture, epidural steroid injections, medications, and cervical traction. There was no documentation of physical medicine treatment or response. The 8/28/14 treating physician report cited intermittent grade 6/10 neck pain radiating into the right upper extremity. Pain was increased with right rotation and prolonged postures. Physical exam documented moderate cervical paravertebral muscle tenderness to palpation, bilateral upper trapezius muscle guarding and spasms, and positive Spurling's on the right. The treatment plan recommended chiropractic treatment, pain management consultation for cervical epidural steroid injection, and medications including Ultram and Fexmid. The 9/17/14 utilization review partially certified the request for Fexmid 7.5 mg #60 to #20 to allow time for downward titration and discontinuation as the guidelines do not

support chronic use. The request for chiropractic treatment one time per week for 3 weeks for cervical traction trial was denied based on an absence of documented benefit with previous conservative treatment to support the medical necessity of chiropractic treatment over a home exercise program. The request for pain management consultation for consideration of cervical spine epidural steroid injection was partially certified to one visit for a pain management consultation considering the exam and imaging evidence.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Fexmid 7.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain) / Antispasticity/Antispasmodics Drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

**Decision rationale:** The California MTUS guidelines recommend the use of cyclobenzaprine (Flexeril) as an option, using a short course of therapy, in the management of acute exacerbations in patients with chronic back pain. Treatment should be brief. This medication is not recommended to be used for longer than 2 to 3 weeks. Guideline criteria have not been met. There is no documentation of an acute exacerbation or pain or evidence as to the length of use of this medication. Given the absence of guideline support beyond 2 to 3 weeks, discontinuation is indicated. The 9/17/14 utilization review modified the request for Fexmid 7.5 mg #60 to #20 to allow for downward titration and discontinuation. There is no compelling reason to support the medical necessity beyond the current medication allowance. Therefore, this request is not medically necessary.

**Chiropractic treatment 1 times per week for 3 weeks to the cervical spine for traction trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174, 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Traction

**Decision rationale:** The California MTUS guidelines state there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities, such as traction. Cervical traction is specifically not recommended. The Official Disability Guidelines do not recommend institutionally based powered cervical traction devices. Guidelines recommend the use of a home patient-controlled cervical traction device for patients with radicular symptoms in conjunction with a home exercise program. Guideline criteria have not been met. There is no clear evidence that this request is for a trial of a home cervical traction unit and not for a trial of a

powered traction device. Records indicate multiple prior recommendations for cervical traction with no evidence if this was trialed in physical therapy and what response was achieved. Given the lack of guideline support and limited available documentation, the medical necessity of this request cannot be established. Therefore, this request is not medically necessary.

**Pain management consultation for consideration of cervical spine ESI: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment in Workers' Compensation (TWC), Neck & Upper Back Procedure Summary last updated 08/04/2014, Evaluation and Management (E&M) Outpatient Visits (Offices).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESIs) Page(s): 46. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations pages 127

**Decision rationale:** The California MTUS guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Guidelines support the use of epidural steroid injections for patient with radicular pain when radiculopathy is documented on physical exam and corroborated by imaging or electrodiagnostic studies, and the patient has been unresponsive to conservative treatment. Guideline criteria have not been clearly met for epidural steroid injection. There is no clear physical exam evidence consistent with imaging evidence relative to nerve root compression. There is no documentation of failed conservative treatment. Therefore, this request is not medically necessary.