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| Case Number: | CM15-0114488 | | |
| Date Assigned: | 06/22/2015 | Date of Injury: | 05/30/2012 |
| Decision Date: | 07/22/2015 | UR Denial Date: | 06/12/2015 |
| Priority: | Standard | Application Received: | 06/15/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Arizona, California
 Certification(s)/Specialty: Family Practice

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 injured worker is a 50 year old female who sustained an industrial injury on 5/30/12. The injured worker was diagnosed as having cervical spondylosis. Currently, the injured worker was with complaints of cervical neck pain. Previous treatments included activity modification, status post anterior cervical disc fusion and medication management. Previous diagnostic studies included radiographic studies and cervical magnetic resonance imaging. The plan of care was for epidural steroid injection and medication prescriptions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient single right C7-T1 epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 45. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Integrated Treatment/ Disability Duration Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural injections Page(s): 47.

Decision rationale: According to the guidelines, the criteria for the use of Epidural steroid injections: Note: The purpose of ESI 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. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case, the claimant's prior MRI in 2-13 showed fusion and priori compression at the C6-C7 level. Recent compression testing is negative. The request for an ESI of C7-T1 is not substantiated and not medically necessary.

Pharmacy purchase of Mobic 15mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 67.

Decision rationale: According to the guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. NSAIDs are recommended as an option for short-term symptomatic relief. In this case, the claimant had been on Percocet for months. Pain scores were not routinely documented. Mobic is an NSAID which is indicated 1st line for mechanical pain and anti-inflammatory properties. The request for Mobic is appropriate and medically necessary.

Baclofen 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Baclofen Page(s): 64.

Decision rationale: According to the guidelines, Baclofen is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain. In this case, the claimant did not have the above diagnoses and the claimant had previously been on Flexeril for several months. Long-term of muscle relaxants is not recommended and the Baclofen request is not medically necessary.

