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| <b>Case Number:</b>   | CM14-0102467 |                              |            |
| <b>Date Assigned:</b> | 07/30/2014   | <b>Date of Injury:</b>       | 12/06/2006 |
| <b>Decision Date:</b> | 09/29/2014   | <b>UR Denial Date:</b>       | 06/06/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/02/2014 |

### 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 Pain Medicine and is licensed to practice in Florida. 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:

A note dated 06/23/14 indicates that the insured has a history of anterior cervical discectomy and fusion of C3-C4 on July 19, 2012, that has been slow to improve. The insured developed right upper extremity complex regional pain syndrome. The claimant was recommended for physical therapy. Note 06/16/14 indicates the advanced cervical myelopathy and complex regional pain syndrome. The insured had degenerative disc disease from C4 to C7 and is reported to be suffering from a new C6 radiculopathy. Note 06/05/14 indicates ongoing complaints of pain in the neck. The insured is reported to be uncomfortable with decreased range of motion and strength diffusely throughout the right upper extremity. There is no discernible weakness in the left side. Magnetic resonance imaging (MRI) of the cervical spine from February 21, 2011 was reported to show degenerative disc disease from C4 to C7 with mild to moderate stenosis at all levels. Operative report 07/19/12 indicate a C3-C4 anterior cervical discectomy and fusion. There is a PR2 dated 06/02/14. It indicates ongoing complaints of pain in the neck, right shoulder and right upper extremity. There is numbness and stabbing into the hand. There is reported to be sensitivity to touch. The insured indicates that Norco taking twice a day is "not strong enough to help." The insured reports a history of stomach irritation and is not a candidate for non-steroidal anti-inflammatory drugs (NSAID) therapy. Examination reported decreased sensation in the right C5 to C7 dermatomes with 4/5 left upper extremity strength and 3/5 right upper extremity strength limited by pain. There was positive Hoffmann's bilaterally. MRI of 02/26/14 was reported to show canal stenosis at C4-C5, C5-C6, C6-C7 as well as neural foraminal narrowing at C3-C4, C4-C5 noted to be severe, at C5-C6 moderate to severe and C6-C7 severe right neural foraminal narrowing. Note indicated that Zanaflex was to be discontinued due to side effects and to be given a trial of Robaxin.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **3 Interlaminar epidural steroid injections on the right at C5, C6 and C7: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI's Page(s): 46.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck, epidural injections.

**Decision rationale:** Routine series of 3 epidurals is not supported under Official Disability Guidelines (ODG) guidelines. There is no indication in the medical records provided for review of extenuating circumstances in support of a series of 3 epidurals in the insured. Therefore, the request for 3 interlaminar epidural steroid injections on the right at C5, C6 and C7 is not medically necessary and appropriate.

### **Hydrocodone/APAP 7.5/325 MG # 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 75-79.

**Decision rationale:** The medical records provided for review indicate that the Hydrocodone is not effective for control of pain. There is no documentation of opioid risk use mitigation through use of tools such as urine drug screen (UDS). In the absence of clinical improvement, continued use of opioid is not supported under Official Disability Guidelines (ODG) guidelines. Therefore, the request for Hydrocodone/APAP 7.5/325 MG # 60 is not medically necessary and appropriate.

### **Zanaflex 2 MG # 90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines antispasticity drugs Page(s): 66.

**Decision rationale:** The medical records provided for review report the insured is not benefiting from the Zanaflex and the treating physician indicated plans to discontinue the medication. As such continued use of Zanaflex is not supported.