

Case Number:	CM13-0006058		
Date Assigned:	01/03/2014	Date of Injury:	07/10/2011
Decision Date:	03/18/2014	UR Denial Date:	07/15/2013
Priority:	Standard	Application Received:	08/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Psychiatry & Neurology, has a subspecialty in Geriatric Psychiatry, Addiction Medicine and is licensed to practice in California and Texas. 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 physician 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:

Records reviewed include 394 pages of medical and administrative records. The claimant is a 50 year old male whose date of injury is 07/10/2011. His primary diagnosis is 722.10, lumbar disk displacement, pain in joint lower leg, and unspecified major depression, recurrent episode. The injury occurred when he was pulling a dresser into a bedroom using an appliance dolly. He was directing the furniture to enter the room when he twisted his back and felt a sharp pain in his lower back. The next day he could not move or get out of bed. The patient has undergone trials of 4 epidural steroid injections, without benefit. Following extensive conservative treatment he underwent lumbar fusion on 02/19/2013, with significant post-op vertigo which has not resolved. He continues to suffer from pain in his back and left knee. He has received conservative treatments including PT, TENS, epidurals, acupuncture, massage, medications, and a knee brace. 07/09/13 ENT evaluation, [REDACTED] notes that the first report of vertigo was dated 04/16/13 causing imbalance and associated symptoms of vision disturbance, jittery eyes along with associated nausea and vomiting. The patient describes his symptoms as an imbalance, especially when looking up or down, causing him to feel uncomfortable-tumbling, tilting and rocking with jumping vision symptoms when bending over, rapid head movements, or changing positions. The patient had been told by a previous specialist (not ENT) that this may be post surgical shock related dizziness. 07/12/13: Visit notes [REDACTED]. The patient continues to pain in his left knee, along with vertigo and occasional nausea. The medications only partially alleviate his pain. Meds include Capsaicin cream, Buprenorphine 0.1mg 4 times per day (may increase to 2 tabs 3 times per day as needed), Venlafaxine 37.5mg 2 tabs, Topamax 100mg 1.5 tabs at night for sleep and nerve pain, Ducoate sodium, Meclizine 25mg 3 times per day, Senokot, Vicodin 4 times per day, and Zofran 4mg 3 daily. Additional prescriptions given

for Buprenorphine 0.25mg take 1-2 tabs every 8 hours as needed, gabapentin 600mg take 1-2 at bedtime, and Ondansetron 4mg #10 take 1 daily as needed. 7/24/13-9/30/13: Physical & Occupational Therapy notes: The patient continues to have dizziness with certain activities (e.g. rolling and bending over) and loses balance when standing. 07/26/2013: Visit note from [REDACTED] [REDACTED] The patient continues to have low back pain with radiation into the left lower extremity, and pain in the left knee. He has started physical therapy and was given a knee brace. He has right knee pain when climbing stairs. He is limited in the type of exercises he can do right now due to dizziness. He does not want to take venlafaxine as it makes him sleepy, and reports that buprenorphine is not helping despite increasing the dose. He feels that Vicodin works better. Medications at this time are venlafaxine 37.5mg 2 tablets daily, Buprenorphine 0.25mg 1-2 tabs every 8 hours as needed, gabapentin 600mg 1-2 at bedtime, and Ondansetron 4mg #10 1 daily as needed. 08/15/2013: Visit note [REDACTED] reports that the patient continues to have pain in the low back radiating to the left lower extremity, pain in the left knee, and imbalance and vertigo. The pain has overall worsened in nature, and he has severe pain in the right knee due to compensating for the left side. Discontinued Buprenorphine and venlafaxine, prescribed Tramadol. Other medications include gabapentin 600mg 1-2 at bedtime and Ondansetron 4mg one daily as needed. 08/15/2013: ENT evaluation by [REDACTED] [REDACTED] reporting no evidence of peripheral or central vestibular disorder, with recommendations made for vestibular rehabilitation exercises to keep the patient active in the form of balance retraining and post-urography. 09/12/2013: Visit note, [REDACTED]. The patient presented for follow up for low back pain (radiating into the

IMR ISSUES, DECISIONS AND RATIONALES

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

Pharmacotherapy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 18-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Antiemetics, Ondansetron (Zofran).

Decision rationale: In this case the patient sustained an industrially related injury ultimately resulting in lumbar fusion in 2013. Subsequent to this he developed vertigo with nausea. He was exposed to a host of other medications, including venlafaxine, Buprenorphine, and Tramadol, all of which have been discontinued, with the exceptions of Gabapentin and Zofran. Apparently he has been most responsive to gabapentin for neuropathic pain, and zofran for the nausea associated with vertigo. Both compounds require monitoring for efficacy and adverse events by a physician as each has a different indication. As such 6 additional pharmacotherapy visits are authorized every 2 months. ACOEM states that Physicians should provide appropriate evaluation, diagnosis and treatment, relying on evidence-based approaches. Absent emergency, trauma, or other red flag situations, initial strategies limit excessive diagnostic testing. Non-invasive treatments are nearly always the primary treatments Superior care generally requires

optimal treatments, pharmacotherapy, and physical activity while limiting excessive physical medicine prescriptions (especially passive modalities) and specialist referrals. Physicians should ascertain the functional demands of affected worker job positions (from the patient's history, visits to the job site, job descriptions and/or quantifications of job demands), ii and identify appropriate work limitations and restrictions, which should evolve as the worker recovers. It is important that physicians educate affected workers about their conditions and the employees' participatory role in recovery and return to maximal function as early as possible to stimulate a focus on function, eliciting and utilizing employee knowledge about tolerated activities and the pace of RTW in the process. (Wynne-Jones 10) Physicians should step beyond their usual medical treatment approach and be cognizant of the important contributions that can be made by other parties, especially those familiar with employee work lives, in the disability prevention process. Physicians should actively communicate and work cooperatively with other stakeholders, including employers, payers, and the affected worker's family members, to help minimize impacts of health conditions, and maintain the full participation of the worker in work and daily living activities. This includes communications required by law for workers' compensation systems. However, physicians should be cognizant of specific limitations and restrictions on communication of medical information within their practice jurisdiction, and in general should limit themselves to communication of information on a need-to-know basis.