

Case Number:	CM13-0007238		
Date Assigned:	12/04/2013	Date of Injury:	06/07/2012
Decision Date:	03/24/2014	UR Denial Date:	07/22/2013
Priority:	Standard	Application Received:	08/05/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working least at 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:

The patient is a 47-year-old male who reported an injury on 06/07/2012. The patient is diagnosed with chronic thoracolumbar pain syndrome, thoracic compression fracture, bilateral posterior leg pain, weakness in the right lower extremity with loss of reflexes, small disc herniation, disc degeneration at multiple levels in the lumbar spine, multiple levels of arthropathy and facet degeneration in the lumbar spine, mild right neural foraminal stenosis at L5-S1 and status post lumbar surgery 2 level in 1994. The patient was recently seen by [REDACTED] on 10/10/2013. Physical examination revealed a midline surgical scar at L3-5 muscle spasms throughout the thoracic, lumbar, and upper gluteals, tenderness along the entire spine at T2-S1, inability to perform range of motion exercises, positive straight leg raising bilaterally, positive LasA"gue's testing bilaterally, diminished reflexes, and diminished strength. Treatment recommendations included continuation of current medication, epidural steroid injection at T11-12, and bilateral SI joint rhizotomies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 50mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: California MTUS Guidelines state antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesic medication, sleep quality and duration, and psychological assessment. As per the clinical notes submitted, there is no evidence or diagnosis of depression or anxiety. There is also no evidence of accompanying psychiatric complaints. The medical necessity has not been established. Therefore, the request is non-certified.

Naprosyn 500mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDS are recommend for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. There is no evidence to recommend 1 drug in this class over another based on efficacy. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient reported 7-9/10 pain. There were not changes in the patient's physical examination that would indicate functional improvement. As guidelines do not recommend chronic use of NSAID medication, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

MSLA 100mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient presents with 7-9/10 pain. There are no changes in the patient's physical examination

that would indicate functional improvement. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.

MSIR (Morphine Sulfate IR) 30mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient presents with 7-9/10 pain. There are no changes in the patient's physical examination that would indicate functional improvement. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.

Topiramate 100mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20.

Decision rationale: California MTUS Guidelines state antiepilepsy drugs are recommended for neuropathic pain. Topiramate has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of central etiology. It is considered for use for neuropathic pain when other anticonvulsants fail. As per the clinical notes submitted, there is no evidence of a failure to respond to previous anticonvulsants prior to the initiation of topiramate. The patient continues to report 7-9/10 pain. Documentation of a significant functional improvement or a significant change in the patient's physical examination was not provided. Based on the clinical information received, the request is non-certified.

T11-12 epidural injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: California MTUS Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Patients should prove initially unresponsive to conservative treatment. As per the clinical notes submitted, it is documented by [REDACTED] on 10/10/2013 that the patient received 50% improvement following a thoracic T11-12 epidural steroid injection. However, documentation of objective measurable improvement with associated reduction of medication use for 6 to 8 weeks following a previous injection was not provided. Therefore, a repeat injection cannot be determined as medical appropriate. Therefore, the request is non-certified.

1 S1 joint rhizotomies: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation the Official Disability Guidelines, Hip & Pelvis (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Sacroiliac joint radiofrequency neurotomy

Decision rationale: California MTUS/ACOEM Practice Guidelines state there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Official Disability Guidelines state sacroiliac joint radiofrequency neurotomy is not recommended. As per the clinical notes submitted, the patient's latest physical examination only revealed tenderness along the entire spine at T2-S1 with painful sacroiliac joint bilaterally. As guidelines do not recommend the requested procedure, the current request is non-certified.