

Case Number:	CM13-0042981		
Date Assigned:	12/27/2013	Date of Injury:	12/17/2001
Decision Date:	04/18/2014	UR Denial Date:	10/15/2013
Priority:	Standard	Application Received:	10/22/2013

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 Anesthesiology, has a subspecialty in Pain Management 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:

The patient is a 40-year-old female who reported an injury on 12/17/2001. The mechanism of injury was not provided. The patient's medication history was noted to include Butrans, a muscle relaxant, Celebrex, and Percocet as of 04/2013. The documentation of 10/09/2013 revealed the patient had constant pain in the lower back, lower extremities, cervical pain, and both upper extremities had pain. The patient's pain was noted to be treated with narcotic pain medications. The physical examination revealed the patient had range of motion of the cervical spine that was markedly limited and flexion and extension, as well as side bending was markedly limited. The patient had diffuse tenderness of the cervical spine with marked tenderness on palpation of the cervical spinous processes in the midline. There were several trigger points involving bilateral paracervical trapezius, and intrascapular area. The patient had a Patrick's and FABER test that were positive with moderate tenderness on the lower lumbar facet joint. The patient had severe tenderness over the sacroiliac joint with positive distraction, thigh thrust, Gaenslen's test, and sacroiliac joint compression test, as well as the sacral thrust test. The motor examination revealed the patient had diffuse weakness of both lower extremities due to pain and the patient had decreased pinprick sensation of the left and right upper extremities and it was diffusely decreased on the left lower extremity. The diagnoses were noted to include status post stimulator explant, sacroiliac joint dysfunction left greater than right, lumbar radiculopathy left greater than right, failed back surgery syndrome, lumbar facet arthropathy, occipital neuralgia, myofascial pain syndrome, cervical radiculopathy, and status post spinal cord stimulator implant. The request was made for medication refills including Percocet, Celebrex, Robaxin, and Butrans, bilateral occipital blocks and a transforaminal epidural injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 OUTPATIENT BILATERAL OCCIPITAL NERVE BLOCK WITH FLUOROSCOPIC GUIDANCE AND ANESTHESIA AT L4-5 &L5-S1: 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), Neck and Upper Back Chapter, Greater Occipital Nerve Block

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Greater Occipital Nerve Block

Decision rationale: Official Disability Guidelines indicate that greater occipital nerve blocks are under study for use in treatment of primary headaches. The clinical documentation submitted for review failed to indicate the patient had complaints of primary headaches. There was a lack of documented rationale for the requested service and an occipital block is not performed in the lumbar region. The request as submitted was for L4-5 and L5-S1. Given the above, the request for 1 outpatient bilateral occipital nerve block with fluoroscopic guidance and anesthesia at L4-5 &L5-S1 is not medically necessary.

1 OUTPATIENT LUMBAR TRANSFORAMINAL EPIDURAL STEROID INJECTION (ESI) AT L4-5, L5-S1 WITH FLUOROSCOPIC GUIDANCE AND ANETHESIA AT GALILEO AMBULATORY SURGER CENTER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESI),.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESI), Page(s): 46. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, EPIDURAL STEROID INJECTION, 46

Decision rationale: California MTUS Guidelines recommend for an epidural steroid injection, there should be objective documentation on physical examination indicating the patient has radiculopathy and the radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing and the patient's pain must be initially unresponsive to conservative treatments. The clinical documentation submitted for review indicated the patient had decreased pinprick sensation of the bilateral upper extremities and diffusely decreased on the left lower extremity; however, there was lack of documentation indicating a specific myotomal or dermatomal finding. Additionally, there was lack of documentation of an MRI or electrodiagnostic testing and a lack of documentation the patient was initially unresponsive to conservative treatment. The submitted request failed to indicate a laterality. Given the above, the request for 1 outpatient lumbar transforaminal epidural steroid injection (ESI) at L4-5, L5-S1 with fluoroscopic guidance and anesthesia at Galileo Ambulatory Surgery center is not medically necessary.

BUTRANS 20MCG #4: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ONGOING MANAGEMENT Page(s): 60,78.

Decision rationale: California MTUS Guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, objective decrease in the VAS score, and evidence that the patient is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the patient had been taking the medication since 04/2013. There was lack of documentation of the recommended documentation per California MTUS. There was lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for pharmacy purchase of Butrans 20 mcg #4 is not medically necessary.

ZANAFLEX 4MG #60, 1 REFILL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63.

Decision rationale: California MTUS Guidelines recommend muscle relaxants as a second-line option for the short-term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the patient had been on the medication since 04/2013 and there was lack of documentation of objective functional improvement. There was lack of documentation indicating a necessity for refill x1. Given the above, the request for pharmacy purchase of Zanaflex 4MG #60, 1 refill is not medically necessary.

CELEBREX 200MG #60 (2REFILLS): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CELEBREX Page(s): 22.

Decision rationale: California MTUS Guidelines indicates that Celebrex is an NSAID and is the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. The patient was had been on the medication since 04/2013. The clinical documentation submitted for review failed to indicate the patient had

an objective decrease in the VAS score and an objective functional benefit. There was lack of documentation indicating necessity for 2 refills. Given the above, the request for pharmacy purchase of Celebrex 200MG #60 (2 refills) is not medically necessary.

PERCOCET 10/325 MG #120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MEDICATIONS FOR CHRONIC PAIN Page(s): 60,78.

Decision rationale: California MTUS Guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, objective decrease in the VAS score, and evidence that the patient is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the patient had been taking the medication since 04/2013. There was lack of documentation of the recommended criteria per California MTUS. There was lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for pharmacy purchase of Percocet 10/325 mg #120 is not medically necessary.