MAXIMUS Federal Services

Case Number:	CM13-0056733		
Date Assigned:	12/30/2013	Date of Injury:	06/05/2013
Decision Date:	06/04/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	11/22/2013

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 Preventative Medicine has a subspecialty in Occupational Medicine and is licensed to practice in 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 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 injured worker is a 53 year-old male who is reported to have sustained work related injuries on 06/05/13. On this date he is reported to have bent over and developed low back pain. He currently complains of low back pain radiating into the right foot. He has been treated with oral medications and physical therapy. On physical examination he is reported to have a positive straight leg raise on the right, diminished deep tendon reflexes in the right Achilles and knee, there is tenderness over the right gluteal muscle. FABER, Fortin, and Gaenslens tests are positive on the right. There are reports of myofascial trigger points in the paraspinal musculature. Strength is decreased in the right lower extremity. MRI has revealed disc bulges at L2/3, L3/4, L4/5 and L5/S1. The lateral recess of the left L5 nerve root is reported to be compromised creating a mild to moderate extradural impression.

IMR ISSUES, DECISIONS AND RATIONALES

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

SOMA: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma Page(s): 29.

Decision rationale: The request for Soma is not supported under CA MTUS. Per the guidelines Soma is not recommended due to the potential abuse. While the records reflect myospasm and myofascial trigger points the injured worker does not appear to have any substantive functional improvements with this medication. Therefore, based on guidelines and a review of the evidence, the request for Soma is not medically necessary.

EFFEXOR: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-18.

Decision rationale: The submitted clinical records indicate the injured worker has low back pain with a right lower extremity component. Effexor is recommended for the treatment of chronic neuropathic pain and well as depression. Given the injured worker's clinical presentation this request for Effexor is medically necessary.

A REPEAT EPIDURAL STEROID INJECTION: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The submitted clinical records indicate the injured worker has objective evidence of the right lower extremity radiculopathy by examination. Imaging suggest foraminal compromise that has resulted in the radicular symptoms. A lumbar epidural steroid injection is clinically indicated and supported under CA MTUS. Therefore, the request for Epidural Steroid Injection is medically necessary.

A GANGLION IMPAR BLOCK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Lumbar Sympathetic Block.

Decision rationale: The submitted clinical records indicate the injured worker has low back pain with radiation into the right lower extremity. There is reported tenderness over the gluteus with positive findings on examination of sacroiliac joint dysfunction. There is no indication that

the injured worker has received focused conservation management other than for low back pain. Therefore, the request for Gangolian Impar Block is not medically necessary.

A BILATERAL GLUTEAL MYOFASCIAL TRIGGER POINT INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: The records report the injured worker has myofascial trigger points. However, the location and presence of a twitch response is not adequately documented. CA MTUS notes that a radiculopathy must not be present for consideration of trigger point injections. As there is an active radiculopathy the request does not meet CA MTUS treatment guidelines. The request for Bilateral Gluteal Myofascial Trigger Point Injections is not medically necessary.

PHYSICAL THERAPY: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Physical Therapy.

Decision rationale: The injured worker continues to have low back pain with radiculopathy. The records indicate previous benefit with overall improvements in daytime pain levels. As such additional Physical Therapy is medically necessary.

RETRO: TORADOL INJECTION: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The submitted clinical records indicate the injured worker has low back pain with a radicular component. The injured worker had an exacerbation and the provision of Toradol for pain relief is medically necessary and appropriate.