

Case Number:	CM13-0060139		
Date Assigned:	12/30/2013	Date of Injury:	09/17/2011
Decision Date:	08/18/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/03/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 37 year-old male was reportedly injured on September 17, 2011. The mechanism of injury is noted as a slip and fall type event. The most recent progress note, dated November 22, 2013, indicates that the injured worker was discharged from care. A "special report" was filed on December 10, 2013. There were complaints of low back pain and sacroiliac joint dysfunction. Again it is noted that the injured worker had been discharged from the practice. Multiple physical therapy notes, dating back to the year 2012, are noted. The physical examination completed by the AMD noted a 5'9", 240 pound individual in no acute distress. A decrease in lumbar spine range of motion is noted. Motor function is described as 5/5. Diagnostic imaging studies objectified degenerative changes and the electrodiagnostic assessment clearly established no radicular component. Previous treatment includes medications and multiple conservative interventions. A request was made for physical therapy, topical compounded preparations, oral medications and repeat injections and was not certified in the pre-authorization process on November 20, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG #120 WITH TWO REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78 OF 127.

Decision rationale: This is in opioid medication designed to address moderate to severe breakthrough pain. There are limited medical records to establish that any such pain has had any response to the use of this medication. As such, there is no objectified efficacy presented. Furthermore, it is not clear if the treating provider is involved in this case. As such, there is no clinician noted to establish and monitor the treatment plan. No medical necessity is noted in the records reviewed. Therefore the request is not medically necessary and appropriate.

AMBIEN 10MG #60 WITH ONE REFILL: 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), pain chapter, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter updated July, 2014.

Decision rationale: It is noted that the MTUS does not address this medication. The parameters noted in the chronic pain chapter of the ODG were used. This medication is a non-benzodiazepine preparation approved for short-term use of up to approximately six weeks. There is no indication for chronic, indefinite or long-term use of this medication. There are no recent progress notes establishing any efficacy or utility for this medication. As such the request is not medically necessary.

PHYSICAL THERAPY FOR THE LUMBAR SPINE (9 SESSIONS): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288.

Decision rationale: The records reflect a partial certification for physical therapy has been endorsed several months ago. Furthermore, the records also indicate that the primary treating provider has discharged this individual from care. As such, when noting the date of injury, the previous care, the recent endorsement of a course of physical therapy there is no indication for continued use at this time. At most, transition to home exercise protocol is all that would be supported in the ACOEM Guidelines. No medical necessity is identified and therefore the request is not medically necessary and appropriate.

COMPOUNDED CREAM TRAMADOL 20%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 OF 127.

Decision rationale: As outlined in the MTUS, use of such preparations are largely experimental and the limited medical records presented for review do not indicate any efficacy, utility or reduction in pain complaints with the use of this medication. It is also noted that a permanent stationary status had been reached and this medication is not indicated for chronic, indefinite use. As such, no medical necessity is established in the records presented for review. The request is not medically necessary and appropriate.

SOMA 325MG #60 WITH TWO REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29 OF 127.

Decision rationale: As outlined in the MTUS (and ACOEM) guidelines this medication is not recommended. Furthermore, this medication is not recommended for long-term or chronic/indefinite use. This is a centrally excellent skeletal muscle relaxant whose primary metabolite is meprobamate, a controlled substance. When noting the limited clinical information presented for review, the ongoing complaints of pain and no noted efficacy or utility with medication there is no medical necessity established for this preparation. The requested Soma 325mg #60 with two refills is not medically necessary and appropriate.

VOLTAREN XR 100MG #60 WITH TWO REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111, 112 OF 127.

Decision rationale: This medication is a nonselective non-steroidal and is not recommended for a first-line use. When noting the date of injury, the ongoing complaints of pain, the unchanging physical examination there is no clinical indication that there has been any successful implementation of this preparation. Therefore, there is no medical necessity established in the progress notes presented for review. The request is not medically necessary and appropriate.

A THIRD RIGHT SI JOINT STEROID INJECTION FOR HIP ARTHROGRAPHY WITH ANESTHESIA AND FLUOROSCOPY: 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 Low Back Disorders; Clinical Measures, injection therapy-Sacroiliac Injections, accessed electronically.

Decision rationale: As outlined in the ACOEM Guidelines, sacroiliac joint injections are not recommended for acute, subacute or chronic low back pain as there is insufficient evidence of any noted efficacy or utility. Furthermore, there are complaints of lower extremity involvement indicating a radicular component which are a contraindication for sacroiliac joint injections. Lastly, two separate injections have been completed and the series of 3 are not supported in the literature. Therefore, based on the limited clinical ration presented for review medical necessity has not been established. Therefore the request is not medically necessary and appropriate.

A SI JOINT ARTHROGRAM: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), chapter 7, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 7, page 127.

Decision rationale: The records reflect a previous evaluation and certification of this request. However, there is no physical examination evidence or plain x-ray evidence to suggest any intra-articular pathology. As such, arthrography for the sequelae joint is not supported or medically necessary based on the records presented for review. The request is not medically necessary and appropriate.