

Case Number:	CM13-0062538		
Date Assigned:	12/30/2013	Date of Injury:	05/19/2011
Decision Date:	05/16/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	12/06/2013

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, Pain Medicine 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 injured worker is a 43-year-old female who reported an injury on 05/19/2011. The worker was injured while walking in patients and sitting them down for treatment. Lumbar spine MRI dated 04/05/2013 revealed a 1 mm to 2 mm annular disc bulge at L4-5 with signal characteristics suggesting an annular tear mildly encroaching on thecal sac without nerve root encroachment; mild degenerative changes to L5-S1. Per the clinical note dated 10/15/2013, the injured worker reported pain to the bilateral low back, right worse than left radiating to the right buttocks, right anterior thigh, and into the right lower extremity. The injured worker reported an aggravation of her bilateral low back pain and bilateral extremity radicular pain. The injured worker reported all activities and movement aggravated and exacerbated the pain. Upon the physical exam, the injured worker was noted to have tenderness to palpation of the lumbar paraspinal muscles. Lumbar and lower extremity ranges of motion were restricted by pain in all directions. Lumbar discogenic and lower extremity provocative maneuvers were positive. Sacroiliac provocative maneuvers were negative bilaterally, except Patrick's maneuver was positive on the right side. Nerve root tension signs were negative bilaterally. Muscle stretch flexes were documented as 1 and symmetrical bilaterally in all limbs. The clinical documentation noted muscle strength to be 5/5 in all limbs except for 4/5 in the bilateral quadriceps, hamstrings, gastrocnemius and soleus, and 4-/5 in the right anterior tibialis. There was noted decreased sensation to touch in the right L5 dermatome. The injured worker had diagnoses including bilateral L5 versus S1 radiculopathy, left S1 radiculopathy, left par central L5-S1 disc protrusion with annular disc tear that touches the left S1 nerve root, lumbar disc protrusion, right lumbar radiculopathy, lumbar stenosis, lumbar facet joint atrophy, and lumbar sprain/strain. The request for authorization for medical treatment DWC Form RFA dated 10/25/2013 was submitted with requests for Medrol Dose pack, hydrocodone 5/325 mg every 6 hours as needed for pain, ibuprofen 600 mg 4 times a day,

refill capsaicin cream, in-office random 12 panel urine drug screen, and fluoroscopically-guided bilateral L5-S1 transforaminal epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

MEDROL DOSE PACK: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), LOW BACK, ORAL CORTICOSTEROIDS.

Decision rationale: ACOEM states, the use of oral corticosteroids for patients with low back pain is not recommended. The Official Disability Guidelines further state oral corticosteroids are not recommended for patients with knee pain and chronic pain. The guidelines note they are recommended in limited circumstances for acute radicular pain. The criteria for the use of corticosteroids (oral/parenteral for low back pain) includes: injured workers should have clear-cut signs and symptoms of radiculopathy; risks of steroids should be discussed with the injured worker and documented in the record; and the injured worker should be aware of the evidence that research provides limited evidence of effect with this medication and this should be documented in the record; current research indicates early treatment is most successful; treatment in the chronic phase of injury should generally be after a symptom-free period with subsequent exacerbation or when there is evidence of a new injury. The documentation provided for review dated 10/15/2013 noted the injured worker had tenderness upon palpation of the lumbar paraspinal muscles and the lumbar spine and lower extremity range of motion were restricted by pain in all directions. There was noted decreased sensation to the right L5 dermatome. Lumbar discogenic and lower extremity provocative maneuvers were positive. It was documented the injured worker was to have an epidural steroid injection for the ongoing pain; no documentation was provided for review that the injection had taken place, and the efficacy of the injection was not indicated. It has been recommended in limited circumstances as noted below for acute radicular pain. Not recommended for acute non-radicular pain (i.e. axial pain) or chronic pain. There was no documentation that there was a new injury to the injured worker. There was no Final Determination Letter for IMR Case Number CM13-0062538. 4 documentation provided that there was a diagnosis of acute radicular or acute non-radicular pain. Therefore, the request for the Medrol Dose-pack is non-certified.

HYDROCODONE 5/325MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
CHRONIC PAIN; OPIOIDS Page(s): 78.

Decision rationale: The California MTUS guidelines note there should be ongoing review and documentation of pain relief, functional status, appropriate medication use, and the side effects of the medication being ordered. The guidelines recommend providers should perform a complete pain assessment including current pain levels, the least reported pain over the period of time from the previous assessment, the injured worker's average pain, intensity of pain after taking the opioid, and how long it takes for the opioid to take effect, and how long that it lasts. Satisfactory response to treatment should be documented including decreased pain, increased level of function, or improved quality of life. The documentation provided for review noted the injured worker was complaining of bilateral low back pain, right worse than left, radiating to the right buttocks, right anterior thigh, and right lower extremity. There was a lack of documentation provided for review indicating the current pain levels, the least reported pain over the period of time since the last assessment, the average pain levels the injured worker had, the intensity of pain after taking the opioid or how long it took to take effect with how long that it lasted. There was a lack of documentation provided indicating the injured worker had decreased pain or increased level of function with improved quality of life. There was also no documentation indicating whether the injured worker had adverse side effects or aberrant or non-adherent drug-taking behaviors. The request did not indicate the frequency at which the medication was prescribed in order to determine the necessity of the medication. Additionally, the request did not indicate the requested quantity of the medication. Therefore, the request for the hydrocodone 5/325 mg is non-certified.

CAPSAICIN CREAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
CAPSAICIN, Page(s): 28.

Decision rationale: The decision for the capsaicin cream is non-certified. California MTUS Guidelines state capsaicin is recommended only as an option in patients who have not responded to other treatments or are intolerant to other treatments. Although topical capsaicin has moderate to poor efficacy it is recommended only as an option for patients who have not responded to other treatments. Within the documentation provided for review there was a lack of documentation indicating the injured worker was not responsive to or was intolerant of other treatments. The request did not include frequency, quantity, or strength of the capsaicin cream. Therefore, the request is non-certified.