

Case Number:	CM13-0063631		
Date Assigned:	12/30/2013	Date of Injury:	02/04/2010
Decision Date:	04/16/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/10/2013

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 Anesthesiology and 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 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 64-year-old female who reported an injury on 02/04/2010. The patient was reportedly injured secondary to repetitive trauma. The patient is currently diagnosed with lumbago, displacement of lumbar intervertebral disc without myelopathy, lumbar neuritis, lumbar facet joint syndrome, myalgia, healed compression fracture at T12, L2 and L4, annular tears at L1-L4, and neural foraminal narrowing at L1-S1. The patient was seen by [REDACTED] on 11/06/2013. The patient reported persistent lower back pain with radiation to bilateral lower extremities. The patient currently utilizes a lumbar support brace, a home exercise kit, and a transcutaneous electrical nerve stimulation (TENS) unit. Current medications include hydrochlorothiazide, K tab, Ecotrin, naproxen, omeprazole, zolpidem, gabapentin, nabumetone, codeine, and meclizine. Physical examination on that date revealed positive Kemp's testing and facet loading maneuver bilaterally, absent reflexes at the knee, diminished ankle reflexes bilaterally, sensory deficit, paraspinal tenderness, muscle guarding, spasm bilaterally, positive straight leg raising, and decreased range of motion. The treatment recommendations at that time included a lumbar epidural steroid injection, lumbar facet joint blocks at medial branch level of L1-S1, clearance from an internal medicine specialist and psychological evaluation prior to proceeding with the procedure, a blood glucose level, durable medical equipment, and continuation of current medication. It is also noted that the patient underwent an MRI of the lumbar spine on 06/26/2012, which indicated facet arthropathy at L1-S1, old compression fractures at T12, L2 and L4, and disc protrusion at L1-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

EPIDURAL STEROID INJECTION (ESI) AT DISC LEVELS L4-L5 AND L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

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

Decision rationale: The Chronic Pain Guidelines indicate that epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehab efforts. As per the documentation submitted, the patient demonstrated signs and symptoms of radiculopathy upon physical examination. However, there is no documentation of this patient's unresponsiveness to recent conservative treatment including exercises, physical methods, non-steroidal anti-inflammatory drugs (NSAIDs), and muscle relaxants. There is also no indication of this patient's active participation in a functional rehabilitation program to be used in conjunction with the injection therapy. Therefore, the patient does not currently meet criteria for the requested service. As such, the request is non-certified.

FACET JOINT BLOCKS AT THE MEDIAL BRANCH AT LEVELS L1-L2, L2-L3, L3-L4 AND L5-S1 BILATERALLY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 181 and 183. Decision based on Non-MTUS Citation ODG, Low Back Chapter, facet joint diagnostic blocks (injections) section.

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) Low Back Chapter, Facet Joint Diagnostic Blocks.

Decision rationale: he MTUS/ACOEM Guidelines indicate that invasive techniques, such as facet joint injections are of questionable merit. The Official Disability Guidelines indicate that clinical presentation should be consistent with facet joint pain, signs and symptoms. As per the documentation submitted, there is no evidence of an exhaustion of conservative treatment including home exercise, physical therapy, and non-steroidal anti-inflammatory drugs (NSAIDs). Additionally, facet joint injections are limited to patients with low back pain that is non-radicular and at no more than two (2) levels bilaterally. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

MEDICAL CLEARANCE FROM AN INTERNAL MEDICINE SPECIALIST AND PSYCHOLOGICAL EVALUATION PRIOR TO PROCEDURE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

BLOOD GLUCOSE DRAW: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

COLD UNIT:

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 155.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The MTUS/ACOEM Guidelines indicate that physical modalities have no proven efficacy in treating acute low back symptoms. At home local applications of heat or cold as effective as those performed by therapists. As per the documentation submitted, there is no mention of a contraindication to at home local applications of cold packs as opposed to a motorized unit. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request is non-certified.

HOME LUMBAR TRACTION UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Disorders Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Traction.

Decision rationale: The MTUS/ACOEM Guidelines indicate that physical modalities have no proven efficacy in treating acute low back symptoms. The Official Disability Guidelines do not recommend using powered traction devices, but a home based patient controlled gravity traction may be a non-invasive conservative option, if used as an adjunct to a program of evidence based conservative care. As per the documentation submitted, there is no evidence of this patient's active participation in a functional rehabilitation program to be used in conjunction with the traction device. Based on the clinical information received, the request is non-certified.

LUMBAR SACRAL ORTHOSIS (LSO) BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The MTUS/ACOEM Guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As per the documentation submitted, the patient does not demonstrate significant instability upon physical examination. It is also noted that the patient currently utilizes a lumbar support brace. The medical necessity for an additional brace has not been established. Therefore, the request is non-certified.

CANE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Hip and Pelvis Chapter - Walking aids (canes, crutches, braces, orthosis, & walkers).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Walking Aids.

Decision rationale: The Official Disability Guidelines indicate that walking aids such as canes are recommended for specific indications. As per the documentation submitted, the patient does not demonstrate significant instability upon physical examination. Therefore, the medical necessity for the requested durable medical equipment has not been established. Therefore, the request is non-certified.

LUMBAR EXERCISE KIT: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Home Exercise Kit.

Decision rationale: The Official Disability Guidelines indicate that home exercise kits are recommended as an option. As per the documentation submitted, the patient currently utilizes a home exercise kit. The medical necessity for an additional home exercise kit has not been established. Based on the clinical information received, the request is non-certified.

K TAB FOR HYPERTENSION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drug.com/pro/potassium-chloride.html>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes Chapter, Hypertension Treatment.

Decision rationale: The Official Disability Guidelines indicate that hypertension treatment is recommended after lifestyle modification. As per the documentation submitted, the patient has continuously utilized this medication. There is no documentation of this patient's current vital signs or evidence of an objective improvement. There is also no documentation of a failure to respond to first line treatment with lifestyle modifications including diet and exercise. The medical necessity has not been established. Therefore, the request is non-certified.

ECOTRIN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Aspirin.

Decision rationale: The Chronic Pain Guidelines indicate that non-prescription medications such as aspirin are recommended. The Official Disability Guidelines indicate that the normal adult dose for pain includes 325 to 650 mg every four (4) hours as needed. As per the documentation submitted, the patient has continuously utilized Ecotrin 81 mg. It is unknown whether the patient currently utilizes aspirin for chronic pain or a separate condition. The medical necessity for the requested medication has not been established. Therefore, the request is non-certified.

OMEPRAZOLE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk, Page(s): 68-69.

Decision rationale: The Chronic Pain Guidelines indicate that proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective non-steroidal anti-inflammatory drug (NSAID). As per the

documentation submitted, there is no evidence of cardiovascular disease or increased risk factors for gastrointestinal (GI) events. Therefore, the medical necessity for the requested medication has not been established. As such, the request is non-certified.

ZOLPIDEM: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines indicate that insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for seven to ten (7 to 10) days. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report difficulty sleeping. Documentation of a satisfactory response to treatment was not provided. Additionally, there is no evidence of a failure to respond to non-pharmacologic treatment. Based on the clinical information received, the request is non-certified.

GABAPENTIN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs). Page(s): 16-18.

Decision rationale: The Chronic Pain Guidelines indicate that antiepilepsy drugs are recommended for neuropathic pain. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered as a first line treatment for neuropathic pain. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. Satisfactory response to treatment has not been indicated. Therefore, the request is non-certified.

NABUMETONE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs). Page(s): 67-72.

Decision rationale: The Chronic Pain Guidelines indicate that non-steroidal anti-inflammatory drugs (NSAIDs) are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Relafen is recommended for osteoarthritis. As per the documentation submitted, the patient does not maintain a diagnosis of osteoarthritis. Additionally, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. It is also noted on the requesting date of 11/06/2013, the patient was advised to discontinue anti-inflammatory medication secondary to hypertension. Based on the clinical information received, the request is non-certified.