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| Case Number: | CM13-0064375 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 06/05/2012 |
| Decision Date: | 04/29/2014 | UR Denial Date: | 11/12/2013 |
| Priority: | Standard | Application Received: | 12/11/2013 |

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 Anesthesiologist, 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 patient is a 32-year-old male who reported an injury on 06/05/2012. The mechanism of injury involved heavy lifting. The patient is diagnosed with lumbar disc bulge, lumbar strain, and L4-S1 spinal stenosis. The patient was seen by [REDACTED] on 11/06/2013. The patient reported 10/10 pain. Physical examination revealed 2+ deep tendon reflexes, decreased sensation in the left lower extremity, 5/5 motor strength, negative straight leg raising, and bilateral trigger points. Treatment recommendations included trigger point injections in bilateral L5 and S1 paraspinal muscles, and continuation of ThermoCare patches, Ultram ER, Lyrica, amitriptyline, Anaprox DS, and tizanidine.

IMR ISSUES, DECISIONS AND RATIONALES

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

10 ACUPUNCTURE SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation and/or surgical intervention. The time to produce functional improvement includes

3 to 6 treatments. Although the patient does present with severe pain and bilateral trigger points, the current request for 10 acupuncture sessions exceeds guideline recommendations. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.

4 TRIGGER POINT INJECTIONS IN THE BILATERAL L5-S1 PARASPINOUS MUSCLES: Upheld

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

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

Decision rationale: California MTUS Guidelines state trigger point injections are recommended only for myofascial pain syndrome. As per the documentation submitted, the patient's physical examination did reveal bilateral trigger points. However, there was no documentation of circumscribed trigger points with palpation of a twitch response as well as referred pain. There is also no documentation of a failure to respond to medical management therapy such as physical therapy, NSAIDs, and muscle relaxants. Based on the clinical information received, the request is non-certified.

ONE PRESCRIPTION FOR TIZANIDINE 4 MG #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Tizanidine (Zanaflex®).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for Pain Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. Efficacy appears to diminish over time and prolonged use may lead to dependence. As per the documentation submitted, the patient's physical examination does reveal bilateral trigger points. However, the patient was issued a prescription for tizanidine 4 mg, 3 times daily, quantity #150. This is greater than a 1 month supply. Guidelines do not recommend long-term use of muscle relaxants. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

ONE PRESCRIPTION FOR THERMACARE PATCHES #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 162. Decision based on Non-MTUS Citation Acoem Practice Guidelines, 2nd Edition (2004)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Acoem Practice Guidelines, 2nd Edition (2004)

Decision rationale: California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. At home local applications of heat or cold are as effective as those performed by therapists. As per the documentation submitted, the patient has utilized ThermoCare wraps since 01/2013. Despite ongoing use, the patient continued to report persistent pain. There was no mention of a contraindication to at home local applications of heat as opposed to a heat wrap. Based on the clinical information received, the request is non-certified.

ONE PRESCRIPTION FOR ULTRAM ER 100MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has utilized Ultram ER 100 mg since 07/2013. Despite ongoing use of this medication, the patient continues to report high levels of pain. There is no change in the patient's physical examination that would indicate functional improvement. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, the request is non-certified.

ONE PRESCRIPTION FOR AMITRIPTYLINE 10/30 MG #100: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: California MTUS Guidelines state antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Amitriptyline is indicated for neuropathic pain. As per the documentation submitted, the patient has utilized amitriptyline 10 mg since 01/2013. Despite ongoing use of this medication, the patient continues to report persistent pain in the lower back with radiation to the left lower extremity. Satisfactory response to treatment has not been indicated. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.