

Case Number:	CM13-0068616		
Date Assigned:	01/03/2014	Date of Injury:	12/30/1992
Decision Date:	04/22/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/19/2013

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 and Rehabilitation, has a subspecialty in Sports 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 patient is a 44-year-old male who reported an injury on 12/30/1992. The mechanism of injury was not stated. The patient is currently diagnosed with chronic pain syndrome, lumbar postlaminectomy syndrome, lumbar radiculitis, lumbar intervertebral disc displacement, lumbar spondylosis, lumbar degenerative intervertebral disc, lumbar stenosis, lumbago, cervicgia, cervical postlaminectomy syndrome, cervical radiculitis, and insomnia. The patient was seen by [REDACTED] on 09/03/2013. The patient reported persistent pain in the neck, low back, and lower extremity. The patient also reported tingling in the upper extremities and numbness in the lower extremities. The patient has been previously treated with lumbar transforaminal epidural steroid injections as well as a previous cervical fusion and lumbar discectomy. Physical examination on that date revealed tenderness to palpation of bilateral lumbar and cervical paraspinals with decreased range of motion, 5/5 strength, and intact sensation. The treatment recommendations included continuation of current medication, a random urine toxicology screen, a repeat epidural steroid injection at L3-4, physical therapy, supportive orthopedic shoes and mattress, and a spine surgery consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUNESTA 2MG 1-2 QHS #50: Upheld

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

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: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. As per the documentation submitted, the patient has continuously utilized this medication. However, there is no documentation of chronic insomnia or sleep disturbance. There is also no documentation of objective improvement following the ongoing use of this medication. There is no evidence of a failure to respond to non-pharmacologic treatment. Based on the clinical information received, the request is non-certified.

FLEXERIL 10MG TID PRN #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants 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 in patients with chronic low back pain. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no documentation of palpable muscle spasm or spasticity upon physical examination. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

LIDODERM Q12 HOURS #120: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. Lidocaine is indicated for neuropathic or localized peripheral pain after there has been evidence of a trial of first line therapy. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is also no evidence of a failure to respond to a trial of first line therapy. Based on the clinical information received, the request is non-certified.

RANDOM URINE TOXICOLOGY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Urine Drug Testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing, Opioids Page(s): 43, 77 & 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

Decision rationale: California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. As per the documentation submitted, the patient's injury was greater than 21 years ago to date and there is no evidence of noncompliance or misuse of medication. There is also no indication that this patient falls under a high risk category that would require frequent monitoring. Based on the clinical information received, the request is non-certified.

REPEAT BILATERAL L3-4 TRANSFORAMINAL EPIDURAL STEROID INJECTION:
Upheld

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

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

Decision rationale: California MTUS Guidelines state 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's physical examination on the requesting date of 09/03/2013 revealed 5/5 motor strength, intact sensation, and negative straight leg raising. There is no documentation of radiculopathy. There were no imaging studies or electrodiagnostic reports submitted for review. There is no documentation of a recent unresponsiveness to conservative treatment. It is also noted that the patient was treated with a transforaminal epidural steroid injection on 04/09/2013. There was no documentation of at least 50% pain relief with an associated reduction of medication use following the initial injection. Based on the clinical information received, the request is non-certified.

PHYSICAL THERAPY FOR LUMBAR SPINE, LAND 2 TO 3 DAYS A WEEK FOR SIX WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. As per the documentation submitted, the patient has been previously treated with physical therapy. Documentation of objective functional improvement following the initial course of physical therapy was not provided. The current request for physical therapy 2 to 3 times per week for 6 weeks exceeds guideline recommendations. Based on the clinical information received, the request is non-certified.

SUPPORTIVE ORTHOPEDIC SHOES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 371.

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, Shoes.

Decision rationale: Official Disability Guidelines state shoes are recommended as an option for knee osteoarthritis. There is no documentation of knee osteoarthritis. The patient's physical examination of bilateral lower extremities did not reveal any significant musculoskeletal or neurological deficit. The patient demonstrates 5/5 motor strength in bilateral lower extremities with intact coordination. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request is non-certified.

SUPPORTIVE ORTHOPEDIC MATTRESS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Mattress Selection, Low Back

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 Chapter, Mattress Selection.

Decision rationale: Official Disability Guidelines do not recommend using firmness as sole criteria for mattress selection. Mattress selection is subjective and depends on personal preference and individual factors. As per the documentation submitted, the patient does not demonstrate significant instability. It is only noted that the patient demonstrated tenderness to palpation with decreased range of motion of the lumbar spine. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request is non-certified.

SPINE SURGERY CONSULTATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. As per the documentation submitted, the patient does report persistent lower back and neck pain. The patient has previously undergone cervical fusion and lumbar discectomy. However, there is no documentation of an exhaustion of conservative treatment prior to the request for a specialty referral. There were no imaging studies or electrodiagnostic reports submitted for this review. The patient's physical examination does not reveal any significant musculoskeletal or neurological deficits. Based on the clinical information received, the request is non-certified.