MAXIMUS Federal Services

Case Number:	CM14-0000089		
Date Assigned:	01/10/2014	Date of Injury:	04/06/2009
Decision Date:	06/16/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	12/31/2013

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 Maryland. 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 49 year old female with a work injury dated 4/6/09. Her diagnoses include lumbar radiculopathy, right side worse than left, secondary to HNP of the lumbar spine, facet arthropathy of the right L4-5 and L5-S1 facet joints, chronic pain syndrome, and myofascial lumbar spine syndrome. A 9/3/13 primary physician progress report states that the patient presents for follow-up regarding her low back and bilateral leg symptoms. She states her pain is 5-6/10 on the pain scale. She is status post L5-S1 microdiscectomy on 5/30/2013. She states that she is slowly improving. She continues to note lower extremity radicular symptoms with numbness, tingling, and burning down her posterior thigh to the posterior calf to her heels. She states the pain is worse with any activity such as prolonged walking, sitting, and standing. She also notes right-sided muscle spasms and increased pain with extension. She attempts a home exercise program and a stretching routine as tolerated. She states the majority of her pain is coming from her back. She states it is 80% low back pain. She describes the low back pain as stabbing, aching, and throbbing. She continues with chiropractic/physiotherapy. In regard to medications, she is currently taking Norco 10/325 mg 2 times per day, senna-S 8.6/50 mg 1-2 tabs per day for opiate-induced constipation, Terocin patches, and Zanaflex 4 mg p.r.n. spasm. She states these medications help decrease her pain from 8/10 without the medications to 4-5/10 with the medications. She does note GI upset and occasional constipation that is relieved with the senna. The comprehensive interval history form and pain diagram were reviewed in detail with the patient. On physical exam the patient is in no acute distress. Her gait is normal. Her spine exam reveals decreased range of motion in all planes of the lumbar spine. Incision is clean, dry, and intact. She has positive facet loading on the L4-5 and L5-S1 facets, and positive muscle spasm of the bilateral lumbar paravertebral musculature. An MRI dated 12/11/2012 from [redacted] notes degenerative joint disease and facet arthropathy with L5-S1 right

paracentral protrusion and annular fissure slightly contacting the right S1 nerve root. A CURES report dated 9/03/2013 is consistent with current providers.

IMR ISSUES, DECISIONS AND RATIONALES

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

TEROCIN PATCH: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56, 105, 111-113.

Decision rationale: A Terocin patch contains: Menthol 4%; Lidocaine 4%. Per the MTUS Chronic Pain Guidelines, topical lidocaine in the form of a cream, lotion, or gel is not indicated for neuropathic pain. The MTUS Chronic Pain Guidelines state that lidocaine in a patch form may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). Due to the fact that documentation submitted does not show evidence of intolerance to oral medications, a failure of first-line therapy, and no indication of postherpetic neuralgia in this patient, the request is not medically necessary.

CYCLBENZAPRINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: The prospective use for Cyclobenzaprine is not medically necessary per MTUS guidelines. The MTUS Chronic Pain Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. Furthermore, the request as written does not indicate the duration, dosage or frequency. The request for Cyclobenzaprine is not medically necessary and appropriate.

PROSPECTIVE USAGE OF HYDROCODONE/APAP 10/325: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Opiods Page(s): 76-80.

Decision rationale: The MTUS Chronic Pain Guidelines states that opioids should be discontinued if there is no overall improvement in function and to continue opioids if there is improving functioning and pain. The documentation submitted for review reveals that there is no indication that the medication has improved the patient's pain or functioning to a significant degree. Furthermore, the request as written does not indicate an amount of Hydrocodone/APAP 10/325. Therefore, the request is not medically necessary and appropriate.

MRI OF THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: The ACOEM Guidelines recommends imaging studies should be reserved for cases in which surgery is considered, or if there is a red-flag diagnosis. The ACOEM Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment. The documentation submitted does not reveal new findings or a red flag diagnoses. The patient has had similar long term symptoms since her surgery. There is no documentation how an MRI would alter this treatment plan. The request for a lumbar MRI is not medically necessary and appropriate.

RIGHT L4-5 AND L5-S1 FACET JOINT BLOCK: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The ACOEM guidelines state that facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic block. The ODG states that facet injections should be limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. The documentation provided for review indicates that the patient has radicular pain, therefore the request for a right L4-5 and L5-S1 facet joint block is not medically necessary.

OMEPRAZOLE: 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 Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk, Page(s): 69.

Decision rationale: There is no documentation within the medical records provided for review indicating that patient meets the MTUS Chronic Pain Guidelines criteria for a proton pump inhibitor, including : (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The MTUS Chronic Pain Guidelines also recommend proton pump inhibitors for dyspepsia due to NSAID use. The documentation does indicate that the patient has GERD and gastrointestinal complaints but the documentation does not indicate that the patient is on NSAID therapy. Furthermore, the request as written has no quantity indicated. Therefore, Omeprazole is not medically necessary and appropriate.