

Case Number:	CM14-0001244		
Date Assigned:	03/26/2014	Date of Injury:	01/09/2011
Decision Date:	06/13/2014	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	01/03/2014

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 Illinois. 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 51 year old male who reported an injury on 01/09/2011. On 01/08/2014 the injured worker had a physical examination. He complained of left sided low back pain that radiated into his left buttock and left posterior thigh; he rated the pain at 5-8/10. He reported that his pain was worse with prolonged sitting and lying and relieved by walking, standing, and change in position. He reports occasional numbness in his posterior thigh. He added that Tramadol and Norco provide minimal relief of symptoms. The injured worker states that he cannot do home exercise due to the low back pain. The objective findings included range of motion 25% of normal, tenderness to palpation in the middle and the left lumbar region, left paraspinous muscles and left buttocks. His motor strength was 5/5 in the right lower extremity and 4/5 in the left lower extremity. His sensation was intact bilaterally. Patellar and Achilles reflexes were 2+ bilaterally and negative clonus. The injured worker had a positive sitting straight leg raise on the left. The treatment plan included encouraging exercise with emphasis on core strengthening, Vicodin and a follow up in 2 months. This review did not contain a request for authorization for medical treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE LEFT S1 TRANSFORAMINAL EPIDURAL STEROID INJECTION: 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 Page(s): 46.

Decision rationale: The request for one left S1 Transforaminal Epidural Steroid Injection is not medically necessary. The CA MTUS Chronic Pain Medical Treatment Guidelines criteria for ESI's include radiculopathy must be documented by physical examination and corroborated by imaging studies and or electrodiagnostic testing. The assessment does not document radiculopathy and the diagnostic studies are not furnished with this review. Therefore, due to lack of clinical support for a left S1 transforaminal epidural steroid injection, the request is not medically necessary.

NORCO 10/325MG, #60 WITH 1 REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiods Page(s): 74-96.

Decision rationale: The request for Norco 10/325mg #60 with 1 refill is not medically necessary. The CA MTUS Chronic Pain Medical Treatment Guidelines for Opioids recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. The injured worker has low back pain that he reports is no relieved with pain medication and the injured worker reported that he is not functional due to the ineffectiveness of pain medication use. The documentation fails to include side effects or a urine drug screen to monitor potential for abuse. In addition, the frequency of Norco use is not noted in the request. Therefore, the request for Norco is not medically necessary.

TRAMADOL 50MG, #60 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRAMADOL (ULTRAM).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS FOR NEUROPATHIC PAIN, Page(s): 82-84.

Decision rationale: The request for Tramadol 50mg #60 with 3 refills is not medically necessary. The CA MTUS Chronic Pain Medical Treatment Guidelines state that Tramadol is not recommended as a first-line oral analgesic. The guidelines also state that a recent Cochrane review found that this drug decreased pain intensity, produced symptom relief and improved function for a time period of up to three months but the benefits were small (a 12% decrease in pain intensity from baseline). Tramadol should not be used as a first line analgesic according to the guidelines and the injured worker reports that he only gets minimal pain relief. The request

lacks dosage frequency. However, there is lack of any previous analgesic used first and due to the lack of effectiveness the request is not medically necessary.

ONE PHYSICAL THERAPY EVALUATION: 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), Low Back and Lumbar and Thoracic (Acute & Chronic), Office Visits.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98.

Decision rationale: The request for one physical therapy evaluation is not medically necessary. The CA MTUS Chronic Pain Medical Treatment Guidelines state that 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The guidelines recommend 8-10 visits over 4 weeks. The documentation indicates the injured worker had prior therapy. There is no indication the injured worker cannot perform a home exercise program at this time. Therefore, the request is not medically necessary.