

Case Number:	CM14-0002448		
Date Assigned:	01/24/2014	Date of Injury:	10/22/2012
Decision Date:	06/16/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/07/2014

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 and Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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 30-year-old-male who was injured on 10/22/12 when he lifted and moved a heavy piece of metal a distance of five feet. He has been diagnosed with lumbar sprain; paraspinal muscle spasm; lumbar radiculitis right lower extremity; depression; and degenerative disc disease (DDD) at L5/S1. According to the 11/19/13 orthopedic report from the provider, the patient presents with severe low back pain that causes pain when he sits or stands. 90% of the time the left leg hurts, and he rarely has right leg pain. The provider states that the patient had one lumbar epidural steroid injection (LESI) previously that provided a few weeks worth of moderate pain relief. The patient used less medication during that timeframe, and this was the reason for requesting a repeat injection. Exam showed positive straight leg raise at 70 degrees, right and left sides, and motor weakness 3-4/5 on right right extensor hallucis longus (EHL) and flexor hallucis longus (FHL). The plan was to place physical therapy on hold due to severe pain; await auth for electromyography (EMG)/ NCV (nerve conduction velocity) bilateral lower extremity; prescribe Norco 10/325 2 tablets three times daily (t.i.d); Restoril 30mg ; Flexeril 7.5mg tid; await psych referral; request memory foam bed; await chiropractic treatment 2x4; Ketoprofen cream; and appeal LESI x2. On 12/27/13 Utilization Review modified the request to allow the EMG/NCV for the left lower extremity; deny the ESI x2 at L5/S1; deny Restoril; Flexeril and modify Norco to allow #45 of the #180 requested; deny the memory foam bed and ketoprofen cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

EPIDURAL STEROID INJECTIONS, TWO (2) AT THE BILATERAL L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS(ESIs) Page(s): 46.

Decision rationale: According to the 11/19/13 orthopedic report from the provider, the patient presents with severe low back pain that causes pain when he sits or stands. 90% of the time the left leg hurts, and he rarely has right leg pain. The provider states that the patient had one lumbar epidural steroid injection (LESI) previously that provided a few weeks worth of moderate pain relief and he used less medication during that timeframe, and this was the reason for requesting a repeat injection. There are no imaging reports provided for review, but on the 7/2/13 report, the provider states the flexion/extension MRI (magnetic resonance imaging) from 4/9/13 showed disc protrusion at L4/5 effacing the thecal sac and bilateral transiting nerve roots, and at L5/S1 broad based central disc protrusion effaces the bilateral transiting nerve roots. There was mention of a prior LESI, but the procedural report and follow-up are not available. The examination does not document a specific dermatomal pattern of pain. The records show the provider first saw the patient on 2/19/13, and first requested the LESI on 7/2/13, then reiterated the request on 8/6/13, 10/1/13 and 11/19/13. It is not known when the patient had the ESI, or the duration of relief. The MTUS states for repeat blocks, there must be at least 50% pain relief with associated reduction of medication for 6-8 weeks. The request is for two LESI injections, but without documentation of the 50% pain relief from the first LESI for 6-8 weeks, the 2nd LESI requested cannot be recommended. The request is not in accordance with MTUS guidelines. As such, the request is not certified.

RESTORIL 30MG, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 24.

Decision rationale: According to the 11/19/13 orthopedic report from the provider, the patient presents with severe low back pain. The MTUS guidelines states long-term use of benzodiazepines is not recommended, and that most guidelines limit use to 4-weeks. The records show the patient has been prescribed Restoril since 10/1/13. The continued use of Restoril over 4-weeks is not in accordance with MTUS guidelines. As such, the request is not certified.

FLEXERIL 7.5MG, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines FLEXERIL; MUSCLE RELAXANTS (FOR PAIN) Page(s): 41-42; 63-66.

Decision rationale: According to the 11/19/13 orthopedic report from the provider, the patient presents with severe low back pain. The MTUS guidelines specifically states this medication is not recommended for use over 3-weeks. The records show that this was prescribed on 8/6/13, 10/1/13, 11/19/13 and had been using cyclobenzaprine since before the provider first evaluated the patient on 2/19/13. The continued use of Flexeril over 3-weeks is not in accordance with MTUS guidelines. As such, the request is not certified.

NORCO 10/325MG, #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids, long-term assessment Page(s): 88-89.

Decision rationale: According to the 11/19/13 orthopedic report from the provider, the patient presents with severe low back pain. On 2/19/13 initial report, the patient was managing pain with ibuprofen 600mg, Tramadol, and Flexeril. The provider prescribed Norco 1-4 tablets/day. There was no assessment of pain or baseline documented with a numeric scale. On 4/2/13 there was no assessment of pain or efficacy of medications. Norco remained at the same dose. On 5/21/13 the pain was reported as 9/10 therapy was not helping; there was no indication whether Norco helped. On 7/2/13 Norco was increased to 2 tablets 3x/day but there was no reported benefit. On 8/6/13 there was no discussion of medication efficacy, or pain assessment, the patient was reported to have a body rash and nail infection. On 10/1/13 pain was rated at 8-9/10, medications were reported to help maintain functional status, but caused severe cognitive impairment. The patient has been on opioids over 6-months. The Long-term users of opioids section of MTUS applies. The MTUS criteria for opioids require documenting pain and functional improvement and compare to baseline. The MTUS states a satisfactory response is indicated by the patient's decreased pain, increased level of function or improved quality of life. If the response is not satisfactory, the MTUS recommends reevaluating the situation and to consider other treatment modalities. The reporting does not discuss baseline pain or function levels and the follow-up reports do not compare pain or function to baseline measurements. The MTUS reporting requirements for use of opioids has not been met. The request is not in accordance with MTUS guidelines. As such, the request is not certified.

PURCHASE OF ONE MEMORY FOAM BED: 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), Mattresses.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar chapter, Mattress selection, and Aetna, Clinical Policy Bulletin:, Hospital Beds and Accessories.

Decision rationale: The patient presents with back pain. I have been asked to review for a TempurPedic bed. The MTUS/ACOEM did not discuss beds. The TempurPedic bed is not a hospital bed, and does not fit the definition of durable medical equipment (DME). Aetna's guidelines specifically recommend against the TempurPedic bed because it is not DME and not primarily medical in nature, is not primarily used in the treatment of disease or injury, and is normally of use in the absence of illness or injury. The TempurPedic bed is not in accordance with Aetna guidelines. As such, the request is not certified.

ONE (1) TUBE OF KETOPROFEN 20% CREAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: According to the 11/19/13 orthopedic report from the provider, the patient presents with severe low back pain. The MTUS specifically states the Food and Drug Administration (FDA) has not approved ketoprofen for topical applications. Also, the MTUS for topical non-steroidal anti-inflammatory drugs (NSAIDs) states "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." The use of topical ketoprofen for the lumbar spine is not in accordance with MTUS guidelines. As such, the request is not certified.