

Case Number:	CM14-0003049		
Date Assigned:	01/29/2014	Date of Injury:	08/30/2010
Decision Date:	06/19/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/08/2014

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 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 injured worker is a 47 year old female who reported an injury on 08/30/2000 due to an unknown mechanism. The information submitted indicated the injured worker was treated for neck pain with numbness, weakness, and tingling to the right arm and low back pain that radiated to the right leg. The injured worker reported functional limitations that included lifting her arm, repetitive movements, walking more than 250 feet, and activities of daily living around her house. The information submitted also indicated that the injured worker's range of motion over the left supraclavicular area was tender, mild generalized tenderness in the sacral, coccygeal, and pelvic areas with full range of motion of thorac and lumbar spine. The information submitted indicated the injured worker had decreased strength in the right upper and lower extremities, muscle spasms in the right cervicobrachial, levator scapula, paraspinal, upper trapezius, pectoralis minor, and middle trapezius. The antalgic gait favored the right, she was hyperflexic on the right, positive Adson's maneuver and a positive straight leg raise on the right. The medication regimen included Neurontin, Tramadol ER and Protonix. There was no request for authorization submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

DIAGNOSTIC ULTRASOUND TO RIGHT SACROILIAC JOINT AND RIGHT PIRIFORMIS WITH POSSIBLE INJECTION: 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), Neck & Upper Back (Acute&Chronic), Ultrasound, Diagnostic(Imaging).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Ultrasound, (Sonography)

Decision rationale: The injured worker was treated for neck pain with numbness, weakness, and tingling to the right arm and low back that radiated to the right leg. The ODG indicate the use of a diagnostic ultrasound when there is scar tissue, adhesions, collagen fiber and muscle spasms. For an SI Joint injection the guidelines also recommend documentation of at least 3 positive exam findings, diagnostic evaluation must first address any other possible pain generators and the patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management for sacroiliac injection. The ODG recommend for piriformis injections the injured worker should be diagnosed with piriformis syndrome and completed a one-month physical therapy trial. Although the injured worker did have muscle spasms, the spasms were not in the sacroiliac region. As for the sacroiliac injection, there was lack of 3 positive exam finding in the sacroiliac area, lack of diagnostic evaluation, and lack of documentation of conservative care. In regards to the right piriformis injection, there is lack of diagnosis of piriformis syndrome, in addition, there is lack of evidence of conservative care. Therefore, per the ODG, the request for diagnostic ultrasound to right sacroiliac joint and right piriformis with possible injection is not medically necessary.

DIAGNOSTIC ULTRASOUND GUIDED TRIGGER POINT INJECTION TO RIGHT TRAPEZIUS AND PARASCAPULAR MUSCLES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Hip & Pelvis (Acute&Chronic), Criteria Of Trigger Point Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRIGGER POINT INJECTIONS Page(s): 122.

Decision rationale: The injured worker had decreased strength in the right upper and lower extremities, muscle spasms in the right cervicobrachial, levator scapula, paraspinal, and upper trapezius, pectoralis minor, and middle trapezius. The California Medical Treatment Utilization Schedule does not recommend trigger point injections in the absence of myofascial pain syndrome. The guidelines also indicate trigger point injections are not recommended when there are radicular signs. The documents submitted indicate signs of radiculopathy such as neck pain with numbness, weakness, and tingling to the right arm. Therefore, per the guidelines, the request for a diagnostic ultrasound guided trigger point injection to right trapezius and parascapular muscles is not medically necessary.

NEURONTIN 300MG #9 WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPSY DRUGS (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPSY DRUGS Page(s): 16-22.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines indicate Neurontin is an anti-epileptic drug and has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The guidelines also indicate a moderate reduction of 30% in pain. There is lack of evidence of response to medication. Therefore, per the California Chronic Pain Medical Treatment Guidelines, the request for Neurotin 300 mg #9 with 2 refills is not medically necessary.

TRAMADOL ER WITH 2 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-95.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines 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. There is a lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug use behaviors and side effects. Furthermore, the request does not indicate a quantity or dosage for the medication. Therefore, per the California Chronic Pain Medical Treatment Guidelines, the request for Tramadol ER with 2 refills is not medically necessary.

ULTRAM ER WITH 2 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-95.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines 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. There is a lack of evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use behaviors and side effects. Furthermore, the request does not indicate a quantity or dosage for the medication. Subsequently, there is a concurrent request for Tramadol. Therefore, the request would be

considered duplicative. As such, per the California Chronic Pain Medical Treatment Guidelines, the request for Ultram with 2 refills is not medically necessary.

PROTONIX WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS-GIT SYMPTOMS & CARDIOVASCULAR RISK.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS
Page(s): 68.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors when the injured worker is on NSAIDs, however, there is lack of evidence of the injured worker being prescribed NSAIDs and lack of evidence of risk for gastrointestinal events in the submitted documents. In addition, the request does not provide a quantity or dosage for the medication. Therefore, per the California Chronic Pain Medical Treatment Guidelines, the request for Protonix with 2 refills is not medically necessary.