MAXIMUS Federal Services

Case Number:	CM14-0003760		
Date Assigned:	02/03/2014	Date of Injury:	12/08/2012
Decision Date:	06/20/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/10/2014

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 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 injured worker is a 45-year-old female who reported an injury on 12/08/2012. The mechanism of injury was not stated. Current diagnoses include degeneration of lumbar or lumbosacral intervertebral disc, pain in the thoracic spine, and myalgia/myositis. The injured worker was evaluated on 11/14/2013. The injured worker reported persistent lower back pain with spasm. Current medications include cyclobenzaprine 10 mg, ibuprofen 800 mg, Norco 10/325 mg, and Robaxin 750 mg. Physical examination revealed no acute distress, difficulty rising from a sitting position, an antalgic gait, diminished normal lumbar lordosis, myofascial changes in the lumbar paraspinous muscles, and limited lumbar range of motion. The injured worker also demonstrated positive straight leg raising bilaterally and hypoesthesia bilaterally in the L4 dermatome. Treatment recommendations at that time included an L4-5 transforaminal epidural steroid injection, a bilateral lower extremity EMG, physical therapy, and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL TRANSFORAMINIAL EPIDURAL STEROID INJECTION AT L4-5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMA 5th Edition, pages 382-383.

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

Decision rationale: The California MTUS Guidelines state epidural steroid injections are recommended for treatment of radicular pain with use in conjunction with other rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Injured workers should also prove initially unresponsive to conservative treatment. As per the documentation submitted, there were no imaging studies or electrodiagnostic reports submitted for review to corroborate a diagnosis of radiculopathy. There is also no mention of an exhaustion of conservative treatment to include exercises, physical methods, NSAIDs, and muscle relaxants. Based on the clinical information received and the California MTUS Guidelines, the request is not medically necessary.

ELECTROMYOGRAPHY TEST OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), EMG, Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electromyography.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state electromyography may be useful to identify subtle, focal neurologic dysfunction in injured workers with low back symptoms lasting more than 3 or 4 weeks. As per the documentation submitted, the injured worker does demonstrate positive straight leg raising and hyperesthesia in the bilateral L4 dermatomes. The injured worker does report bilateral lower extremity weakness, numbness, and tingling. However, Official Disability Guidelines state prior to an electrodiagnostic study, there should be evidence of at least 1 month of conservative therapy. There is no mention of an attempt at conservative treatment prior to the request for an electrodiagnostic study. Therefore, the request is not medically necessary.

6 PHYSICAL THERAPY SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

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

Decision rationale: The 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. There is no specific body part listed in the current request. There is also a lack of information pertaining to the

injured worker's past conservative care and response to that care. Therefore, the request is not medically necessary.

NORCO 10/325: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 79-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the injured worker had failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The documentation provided failed to adequately address the 4A's to support continuation of the medications. Also, there is no frequency or quantity listed in the current request in order to determine necessity. Therefore, the request is not medically necessary.

FLEXERIL 10 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The California MTUS Guidelines state muscle relaxants are recommended as a nonsedating second line option for short term treatment of acute exacerbations. Flexeril should not be used for longer than 2 to 3 weeks. The documenation provided did not address the length of time the patient has been taking this medication or the efficacy. There is no frequency or quantity listed in the current request. Therefore, the request is not medically necessary.

ROBAXIN 750 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The California MTUS Guidelines state muscle relaxants are recommended as a nonsedating second line option for short term treatment of acute exacerbations. Efficacy appears to diminish over time and prolonged use may lead to dependence. The documenation provided did not address the length of time the patient has been taking this medication or the efficacy. There is no frequency or quantity listed in the current request. Therefore, the request is not medically necessary.