

Case Number:	CM14-0103850		
Date Assigned:	08/04/2014	Date of Injury:	07/02/2009
Decision Date:	09/15/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/07/2014

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 & Rehabilitation, and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 53-year-old individual was reportedly injured on July 2, 2009. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated June 3, 2014, indicated that there were ongoing complaints of low back pain. A lumbar decompression surgery was completed in 2010. The injured employee felt that she was "bedridden," and pain was rated 9/10. There was radiation into the right lower extremity. The physical examination demonstrated hypertonic low back, well healed surgical scar, tenderness to palpation, tenderness over the sacroiliac joint, and a decrease in lumbar spine range of motion; Oswestry score was 88%. Diagnostic imaging studies were not presented. Previous treatment included an emergency room evaluation for significant abdominal pain that was diagnosed as epigastric pain of questionable etiology and chronic low back pain status post low back surgery. Additional treatment included the lumbar surgery, multiple medications, postoperative rehabilitation, and other conservative measures. A request had been made for transmittal epidural steroid injections and was not certified in the pre-authorization process on June 26, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRANSFARAMINAL EPIDURAL STEROID INJECTION AT RIGHT L3, L4, AND L5:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46 of 127.

Decision rationale: As outlined in the MTUS, Epidural Steroid Injections can be recommended as an option for radicular pain when there is dermatomal distribution and cooperative findings of radiculopathy. It is noted that a lumbar decompression surgery has been completed, and there are no electrodiagnostic assessments demonstrating a radiculopathy. Given the severity of pain complaints and the nonspecific nature, there is insufficient clinical evidence presented to support the request based on the MTUS literature. Therefore, the request is not medically necessary.

GABAPENTIN 600 MG, # 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20, 49 of 127.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines consider Gabapentin to be a first-line treatment for neuropathic pain. Based on the clinical documentation provided, there is no evidence that the injured employee does not have any neuropathic pain nor are any radicular symptoms noted on physical examination. Therefore, this request for Gabapentin is not medically necessary.

OMEPRAZOLE 20 MG, # 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

Decision rationale: This medication is useful the treatment of gastroesophageal reflux disease. It is used as a protectorant. However, the progress notes do not indicate any history of gastritis, gastric symptoms, or clinical need for such a medication. Therefore, based on the parameters outlined in the MTUS and by the lack of any objective parameters, this is not medically necessary.

DOCUPRENE 100 MG, # 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77 of 127.

Decision rationale: This medication is a stool softener useful for the treatment of constipation. However, there are no complaints of constipation, evidence of gastric distress or difficulties with elimination. Therefore, based on the clinical data presented and by the physical examination evidence, there is no clinical indication for this medication. Therefore, this request is not medically necessary.

ZOFRAN 4 MG, # 10: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain chapter, updated July 2014.

Decision rationale: This is not addressed in either the ACOEM guidelines or the MTUS. The parameters noted in the ODG are employed. This medication has been approved for nausea and vomiting treatment secondary to chemotherapy, radiation therapy or postoperatively. None of these complaints or clinical situations exists. Therefore, based on the clinical information presented for review, this request is not medically necessary.

CYMBALTA 60 MG, # 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 105 of 127.

Decision rationale: MTUS guidelines support Cymbalta as a first-line treatment option for neuropathic pain, especially if tricyclic anti-depressants are ineffective, poorly tolerated or contraindicated. Review, of the available medical records, documents chronic pain since an injury in 2009. Furthermore, the lesion is a nociceptive lesion and non-neuropathic in nature. As such, there is no clinical indication for the continued use of this medication. This request is not medically necessary based on the records presented for review.

ZANAFLEX 4 MG, # 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66 of 127.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha 2-adrenergic agonist that is FDA approved for management of spasticity. It is unlabeled for use in low back pain. Muscle relaxants are only indicated as 2nd line options for short-term treatment. It appears that this medication is being used on a chronic basis, which is not supported by MTUS treatment guidelines. Furthermore, there is no evidence of spasticity only changes consistent with low back muscle spasm. Therefore, this medication is not medically necessary.

PERCOCET 5-325 MG, # 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13 of 127.

Decision rationale: This medication is a particularly potent opioid analgesic and is noted in the MTUS that it is indicated for the short-term management of moderate to severe breakthrough pain. It is a chronic pain situation. Furthermore, the parameters for prescribing this medication, as outlined in the MTUS, are of less note the treatment plan, any changes in diagnosis, and the relative efficacy of the medication. Based in the progress notes presented for review, note these parameters have been addressed in that the functional efficacy of this medication has not been established, there is little in the way of clinical data to support the continued use of this medication. As such, this request is not medically necessary.

FOLLOW UP VISIT (8 WEEKS): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 of 127.

Decision rationale: When noting the date of injury sustained, the current complaints of pain and that there needs to be significant objectification of a treatment plan that is in compliance with the MTUS, there is a clear clinical indication for a comprehensive 5 evaluation. Each of the medications used in treatment of the situation requires a comprehensive clinical evaluation, notation of the efficacy (if any) and why this medication is being utilized. Therefore, this request is medically necessary.

CHIROPRACTIC REHAB THERAPY 3 PER WEEK FOR 3 WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59 of 127.

Decision rationale: CA MTUS guidelines support the use of manual therapy and manipulation (Chiropractic Care) for low back pain as an option. A trial of 6 visits over 2 weeks with the evidence of objective functional improvement, and a total of up to #18 visits over 16 weeks are supported. After review of the available medical records, there is no clinical documentation or baseline level of function to show future subjective or objective improvements with the requested treatment. Additionally, this far out from the date of injury and on the filing the physical examination, there is no indication that additional chiropractic interventions have any efficacy or utility. As such, this request is not medically necessary.