

Case Number:	CM14-0013535		
Date Assigned:	02/26/2014	Date of Injury:	03/21/2011
Decision Date:	08/19/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/03/2014

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 and Rehabilitation, has a subspecialty in Pain Management 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 presented with a date of injury of 3/21/11. A utilization review determination dated 1/17/14 recommends non-certification of cyclobenzaprine, diclofenac, omeprazole, ondansetron, LESI, and CESI. 1/8/14 medical report identifies that the patient is doing markedly better with the recent injection he had in his lumbar spine with substantial relief of his radicular symptoms. He has been having nausea and vomiting since the injection. He states that the medications are giving him both functional improvement and pain relief and helping with his depression. On exam, the patient has a claw hand to the lateral two fingers from a prior unrelated injury. There is tenderness over the paracervical musculature along with muscle spasms. There is some limited ROM. There is positive tenderness over the paralumbar musculature and rectus femoris as well as paralumbar musculature spasm. Unable to heel and toe walk. ROM is limited. There is positive SLR RLE with diminished sensation right L5 and S1 nerve root distributions. Another 1/8/14 medical report notes radicular low back pain 8/10 with LESI performed one month earlier and 25% relief that continues. On exam, only limited ROM of the lumbar spine is noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR EPIDURAL STEROID INJECTION: Upheld

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

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

Decision rationale: Regarding the request for lumbar epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy on exam and imaging and/or electrodiagnostic testing. Regarding repeat epidural injections, guidelines state that repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. Within the documentation available for review, the documentation noted only 25% relief from the prior injection for approximately 1 month at the time of the request with no indication of objective functional benefit or decreased pain medication use. In light of the above issues, the request for a lumbar epidural steroid injection is not medically necessary and appropriate.

CERVICAL EPIDURAL STEROID INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS, 4 Page(s): 46.

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

Decision rationale: Regarding the request for Cervical Epidural Steroid Injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy on exam and imaging and/or electrodiagnostic testing. Within the documentation available for review, there is no documentation of upper extremity pain in a dermatomal distribution with corroborative findings of radiculopathy on exam and imaging and/or electrodiagnostic testing. In light of the above issues, the request for cervical epidural steroid injection is not medically necessary and appropriate.

CYCLOBENZAPRINE 7.5MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASMODICS Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66 of 127.

Decision rationale: Regarding the request for Cyclobenzaprine, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine and a clear rationale for its long-term use despite

the recommendations of the California MTUS. As such the request for Cyclobenzaprine 7.5 mg #30 is not medically necessary and appropriate.

DICLOFENAC 100MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72 of 127.

Decision rationale: Regarding the request for Diclofenac, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is mention of pain relief and functional improvement, but no documentation of quantified pain relief (such as percent pain reduction or VAS scores) and/or specific examples of functional improvement to support long-term use despite the recommendations of the California MTUS. As such, the request for Diclofenac 100mg #30 is not medically necessary and appropriate.

OMEPRAZOLE 20MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISK.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69 of 127.

Decision rationale: Regarding the request for omeprazole, California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, or a risk for gastrointestinal events with NSAID use. It is being utilized for GI prophylaxis, but the records suggest long-term use and there is no documentation of dyspepsia in the past. As such, the request for Omeprazole 20 mg #30 is not medically necessary and appropriate.

ONDANSETRON 4MG #30: 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).

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 Antiemetics (for opioid nausea) Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/pro/ondansetron-odt.html>.

Decision rationale: Regarding the request for ondansetron, California MTUS does not address the issue. ODG cites that ondansetron is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, and gastroenteritis. Within the documentation available for review, the provider notes that the patient has nausea and vomiting since the injection one month prior. However, the records indicate that the patient has been taking ondansetron for some time prior to the injection and there is no indication of how often the patient is having nausea and vomiting or how he has responded to use of the medication to date. Without documentation of efficacy, there is no clear indication for ongoing use of the medication. As such the request for Ondansetron 4 mg #30 is not medically necessary and appropriate.