

Case Number:	CM14-0016168		
Date Assigned:	03/05/2014	Date of Injury:	03/16/2002
Decision Date:	08/08/2014	UR Denial Date:	01/08/2014
Priority:	Standard	Application Received:	02/09/2014

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 and is licensed to practice in Illinois. 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 74-year-old female who reported an injury on 03/16/2002. The mechanism of injury was not provided. On 03/05/2014, the injured worker presented with constant thoracic spine and interscapular region pain, low back pain radiating across the lumbosacral region to the lateral hips, and right hand and arm pain. Current medications included Norco. Upon examination of the lumbar spine, there was tenderness and tightness across the thoracolumbar area and the injured worker ambulated with a cane with a significant left limp. The range of motion was 50% restricted with some tenderness over the left internal and external rotation of the hip. The diagnoses were lumbar radiculopathy, degeneration of the lumbar intervertebral disc, lumbar facet joint pain, back muscle spasm, myalgia and myositis unspecified, and chronic pain syndrome. Prior therapy included heat, ice, rest, gentle stretching, and medications. The provider recommended Mobic 7.5 mg, Zolof 50 mg, and a bilateral facet injection at L4-5 and L5-S1. The provider recommended the facet injection to improve back pain. The request for authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MOBIC 7.5MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 70.

Decision rationale: California MTUS Guidelines recommend the use of NSAIDs for injured workers with osteoarthritis including knee and hip and injured workers with acute exacerbation of chronic low back pain. The Guidelines recommend NSAIDs at the lowest dose for the shortest period in injured workers with moderate to severe pain. Acetaminophen may be considered for initial therapy for injured workers with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular, or renovascular risk factors. In injured workers with acute exacerbation of chronic low back pain, the Guidelines recommend NSAIDs as an option for short term symptomatic relief. The included medical documentation lack an adequate and complete pain assessment of the injured worker. Additionally, the injured worker has been prescribed Mobic since at least 04/2014 and the efficacy of the medication was not provided. Additionally, the provider's request does not include the frequency of the medication in the request as submitted. As such, the request for Mobic 7.5 mg with a quantity of 30 is not medically necessary.

ZOLOFT 50MG #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, (Mental Illness and Stress).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for pain.

Decision rationale: The California MTUS Guidelines recommend antidepressants as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcome but also an evaluation of function, changes in use of analgesic medication, and sleep quality and duration. Side effects including excessive sedation, especially that which would affect work performance, should be assessed. It is recommended that these outcome measurements should be initiated at 1 week of treatment with a recommended trial of at least 4 weeks. An optimal duration of treatment is not known because most double blind trials have been of short duration between 6 to 12 weeks. There is a lack of evidence of an objective assessment of the injured worker's pain level. There is also a lack of evidence of treatment concerning the antidepressant therapy. The frequency was not provided in the request as submitted. Therefore, the request for Zoloft 50 mg with a quantity of 30 is not medically necessary.

ONE (1) BILATERAL FACET INJECTION AT L4-5 AND L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet Joint Block.

Decision rationale: The California MTUS/ACOEM Guidelines state invasive techniques are of questionable merit. They may have benefit for injured workers presenting in the transitional phase between acute and chronic pain. The Official Disability Guidelines further state the criteria for use of a diagnostic block is limited to injured workers with pain that is nonradicular; no more than 2 joint levels injected in 1 session; and failure of conservative treatment to include home exercise, physical therapy, and NSAIDs prior to the procedure for at least 4 to 6 weeks. The provider noted tenderness across the thoracolumbar area, a negative straight leg raise, and range of motion 50% restricted on extension. The included medical documents lack evidence of tenderness over the specific lumbar region, motor strength testing, and a sensory exam. There was lack of documentation of failure of conservative treatment to include physical therapy and medication. As such, the request for 1 bilateral facet injection at L4-5 and L5-S1 is not medically necessary.