

Case Number:	CM14-0018562		
Date Assigned:	04/18/2014	Date of Injury:	11/01/2011
Decision Date:	06/30/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/13/2014

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 Interventional Spine 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:

This case involves a 53 year-old female patient with an 11/1/2011 industrial injury claim. She has been diagnosed with lumbar disc degeneration; cervical disc degeneration; lumbar radiculopathy; cervical radiculopathy; lumbar facet arthropathy; chronic pain; L4/5 annular tear; and NSAID intolerance. According to the 1/21/14 anesthesiology/pain management report from [REDACTED], the patient presents with 8/10 neck and low back pain that radiates to the right lower extremity and right foot pain. Exam reveals a 5', 200 lbs., RHD, F, with cervical and lumbar tenderness and decreased motion. Sensory showed decrease in RLE, no specific dermatome mentioned, SLR was reported to be positive with no specific dermatomal pattern listed, Motor exam showed decreased strength in no specific myotome. A right L4/5 TFESI was requested and on 2/4/14 UR denied it.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT L4-L5 TRANSFORMINAL EPIDURAL: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN TREATMENT GUIDELINES, EPIDURAL STEROID INJECTION,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, EPIDURAL STEROID INJECTIONS (ESIs), 46

Decision rationale: According to the 1/21/14 anesthesiology/pain management report from [REDACTED], the patient presents with 8/10 neck and low back pain that radiates to the right lower extremity and right foot pain. No specific pattern of radiculopathy was described on physical examination, and UR denied the request for a right L4/5 epidural injection. [REDACTED] appealed this on 2/18/14, stating there is decreased sensation in the right L4-5 dermatome. He states motor exam showed decreased strength of the extensor muscles in the flexor muscles along the L4/5 dermatome. MRI shows grade 1 spondylolisthesis L4 on L5 with disc bulge abutting the exiting L4 nerves and mildly compressing the right-side. The updated information provided by [REDACTED] on 2/18/14 appears to meet the MTUS criteria for a right-side L4/5 transforaminal epidural steroid injection. There were clinical exam findings in the L4 dermatome and corroboration with MRI findings. Recommendation is to approve the request.

RESTONE 3-100MG EVERY NIGHT AT BEDTIME #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: According to the 1/21/14 anesthesiology/pain management report from [REDACTED], the patient presents with 8/10 neck and low back pain that radiates to the right lower extremity and right foot pain. She reports moderate difficulty with sleep. I have been asked to review for Restone. Restone is an herbal product, containing melatonin and L-tryptophan. Restone has not been approved by the FDA for the treatment of any medical condition. ACOEM guideline state " Evidence-based medicine focuses on the need for health care providers to rely on a critical appraisal of available scientific evidence rather than clinical opinion or anecdotal reports in reaching decisions regarding diagnosis, treatment, causation, and other aspects of health care decision making. This mandates that information regarding health outcomes in study populations or experimental groups be extracted from the medical literature, after which it can be analyzed, synthesized, and applied to individual patients" Since the Restone has not been FDA approved to treat any medical condition, the request is not in accordance with the ACOEM guidelines that require evidence-based treatment.

ENOVAX - IBUPROFEN KIT TWICE A DAY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN TREATMENT GUIDELINES, NSAIDS,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, 111-113

Decision rationale: The patient presents with 8/10 neck and low back pain that radiates to the right lower extremity and right foot pain. She has been diagnosed with lumbar disc degeneration; cervical disc degeneration; lumbar radiculopathy; cervical radiculopathy; lumbar facet arthropathy; chronic pain; L4/5 annular tear; and NSAID intolerance. [REDACTED] recommended ibuprofen cream for the "above-mentioned diagnosis". I have been asked to review for Enovax ibuprofen kit, twice a day. MTUS states topical NSAIDS are indicated for osteoarthritis of the knee, elbow or other joints amenable to topical treatment. MTUS specifically states: "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder" The use of the ibuprofen topical over the low back or cervical spine is not in accordance with MTUS guidelines.