

Case Number:	CM14-0019544		
Date Assigned:	04/23/2014	Date of Injury:	01/05/2010
Decision Date:	07/03/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	02/17/2014

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 Family Practice, 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 injured worker is a 51 year old female who sustained an injury on 01/05/10. There was no documentation regarding the injured worker's original injury. The injured worker had been followed for complaints of neck pain, right shoulder pain, as well as low back pain radiating to the lower extremities, left side worse than right with associated weakness. The injured worker received one epidural steroid injection to the left from L4 to S1 performed on 07/12/13. Post-injection follow up on 08/12/13 was handwritten. There was no specific functional improvement noted with the epidural steroid injections. It is unclear what the response was to the original epidural steroid injections. The injured worker was placed on Flexeril for acute spasms in the trapezial area. The clinical report from 11/01/13 noted continuing trigger points in the cervical region. There were recommendations for acupuncture. Medications at this visit included Flexeril and Savella. There is a supplemental report from [REDACTED] dated 02/21/14. Per the report, the injured worker had been continuing to suffer from acute muscle spasms in the lumbar paraspinal and trapezial areas as of 02/07/14. This note was not available for review. The injured worker reported no benefits from the use of Zanaflex in regards to active muscle spasms and was switched to Flexeril. [REDACTED] felt that the injured worker did present with evidence consistent with lumbar radiculopathy. Re-review of the physical examination findings noted tenderness to palpation in the lumbar paraspinal musculature. There was decreased sensation to light touch in the dorsal aspect of the bilateral feet. There was also decreased strength noted on dorsa flexion and right extensor hallucis longus action. Straight leg raise was reported as positive bilaterally at 40 degrees. [REDACTED] referred to MRI studies from April of 2010 which were not available for review reporting degenerative disc disease. The injured worker reported that there was clarification regarding the response to the last epidural steroid injections indicating that more than 50% relief had been obtained for approximately three months and the injured worker was

not utilizing narcotic medications. The utilization review report from 02/14/14 modified the request for Naprosyn 550mg, a quantity of 60 only. Omeprazole 20mg, quantity 60 was approved. Neurontin was modified to 600mg, quantity 90. Flexeril as well as the epidural steroid injection was denied. The utilization review report on 03/07/14 did approve a right L4, left L5, and right S1 epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

EPIDURAL STEROID INJECTION TO THE LEFT SHOULDER, 2/7/14: 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 Page(s): 46.

Decision rationale: In regards to the requested epidural steroid injection to the left shoulder from the 02/07/14 report, this request would not have been recommended as medically necessary. It appears that this request was a typographical error including the left shoulder which does not receive epidural steroid injections. It is noted that the request was resubmitted on a later date for a right L4, left L5, and right S1 epidural steroid injection which was approved by utilization review on 03/07/14. Given the incorrect request, this reviewer would not have recommended approval for this procedure.

NAPROSYN 550MG, #100; 2/7/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids Page(s): 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaid Page(s): 67.

Decision rationale: In regards to the request for Naprosyn 550mg, quantity 100, this reviewer would not have recommended this medication as medically necessary. The injured worker was utilizing Naprosyn for musculoskeletal complaints. The 02/14/14 utilization report did modify the request for 60 tablets only. This reviewer would have agreed with this modification. There was no evidence in the clinical documentation to support utilization of Naprosyn at the quantity of 100 as originally requested.

FLEXERIL 7.5MG, #90; 2/7/14: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-67.

Decision rationale: In regards to Flexeril 7.5mg, quantity 90, this reviewer would have recommended this medication as medically necessary. The injured worker was suffering from acute musculoskeletal spasms in the lumbar spine as indicated by the appeal report from [REDACTED] on 02/21/14. This reviewer does agree with the determination made on 03/07/14 that Flexeril was medically appropriate and necessary.

NEURONTIN 600MG, #100; 2/7/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptics Page(s): 16-22.

Decision rationale: In regards to Neurontin 600mg, quantity 100, this reviewer would not have recommended this medication as medically necessary. This was modified on the 02/14/14 utilization review report to a quantity of 90 for a one month supply. This reviewer would agree with this modification for one month of Neurontin to address continuing radicular symptoms in the lower extremities. There was no indication for a quantity of 100 tablets of Neurontin for this injured worker. Therefore, this reviewer would not have recommended this quantity as medically necessary.

OMEPRAZOLE 20MG, #60; 2/7/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

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, proton pump inhibitors.

Decision rationale: In regards to Omeprazole 20mg, quantity 60, this reviewer does agree with the 02/14/14 determination that modified the quantity to 60 tablets to be utilized twice daily. The injured worker would have reasonably required one month of Omeprazole to address gastrointestinal side effects from oral medication regimen. There was no indication to support the quantity of 100 requested for this injured worker. Therefore, this reviewer would not have recommended Omeprazole at the quantity requested at 100 as medically necessary.