MAXIMUS Federal Services

Case Number:	CM14-0115523		
Date Assigned:	08/04/2014	Date of Injury:	03/21/2002
Decision Date:	09/10/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/23/2014

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 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 57 year-old individual was reportedly injured on March 21, 2002. The mechanism of injury is noted as a lifting type event. The most recent progress note, dated June 23, 2014, indicates that there are ongoing complaints of low back and leg pain, noted as 7/10. The physical examination demonstrated a 5'4", 195 pound individual who is hypertensive (146/86) and reported to be in no acute distress. No other physical examination findings are reported. Diagnostic imaging studies objectified a slight increase in the degenerative changes noted on MRI, with no significant spinal canal stenosis. Previous treatment includes multiple medications, multiple pain management interventions and epidural steroid injections. A request had been made for multiple medications and was not certified in the pre-authorization process on July 8, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Injection Bilateral TFE (Transforaminal/Epidural Steroid Injection)at L3 and L5.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS; (Effective July 18, 2009) Page(s): 46.

Decision rationale: When noting the date of injury, the injury sustained, the treatment rendered, the lack of any specific finding on physical examination, the lack of any identification or objectification of nerve root encroachment and the lack of objectification of a radiculopathy with corroborative findings on electrodiagnostic studies; there simply is insufficient clinical evidence presented to support this request. As outlined in the MTUS, objectification of the radiculopathy is a standard. Seeing none, there is no medical necessity established for this procedure.

Medication: Hydroxyzine 50mg, 2 times a day, no refills requested, Quantity: 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 75.

Decision rationale: As outlined in the MTUS, this medication is an antihistamine and is used to treat painful muscle spasm. However, the physical examination did not identify any muscle spasms or indicators that there were any complaints relative to this. As such, there is insufficient clinical information presented for review to support this request. This is not medically necessary.

Medication: Zanaflex 4mg (1-2 every night at bedtime); No refills requested Quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R9792.20 - 9792.26 MTUS; (Effective July 18, 2009) Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: As outlined in the MTUS, this is a centrally acting alpha-2 antigenic agonist approved for the management of spasticity. However, there are no findings of spasticity noted on physical examination, there is no evidence of spinal stenosis or compromise of nerve roots identified on MRI, and the unlabeled use of this medication for chronic low back pain does not appear to be effective as the pain levels continued to be 8/10. As such, there is no clinical indication or medical necessity for continued use of this preparation.

Medication: Lunesta 3mg (one by mouth every night at bedtime) no refills requested Quantity: 3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Pain.

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: It is noted that this medication is not addressed in either the MTUS or ACOEM guidelines. As such, the parameters noted in the ODG are applied. This medication to treat insomnia is indicated for a short-term period of no more than 4 weeks. Furthermore, the sleep hygiene is not discussed in the progress notes and the efficacy of this medication is not established. Therefore, based on the lack of clinical information and appropriate narrative in the progress note this is not medically necessary.

Medication-Narcotic Percocet 1-/325mg 1/2-1 (by mouth, four times a day, as needed for breakthrough pain), no refills requested, Quantity: 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 88.

Decision rationale: Based on the date of injury and the ongoing complaints of pain there are issues relative to pain control. However, as outlined in the MTUS, such medications are indicated for the short-term management of moderate to severe breakthrough pain. Furthermore, the efficacy of this medication should be measured and objectified in the notes and this has not been done. There is no notation of increased functionality, decrease in pain, ability to return to work or any other measure that this medication is demonstrating any utility whatsoever. As such, based on the progress notes presented this is not medically necessary.