

Case Number:	CM14-0119733		
Date Assigned:	08/06/2014	Date of Injury:	07/18/2007
Decision Date:	09/23/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/30/2014

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 Anesthesiology, Pain Medicine and is licensed to practice in Florida. 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 71-year-old male who reported an injury on 07/18/2007 due to slipping on a freshly waxed floor and experiencing back pain. Diagnoses were lumbar myoligamentous injury with facet arthropathy, bilateral lower extremity radicular symptoms with documented L5-S1 radiculopathy bilaterally, status post anterior/posterior spinal fusion at L5-S1, right knee internal derangement, status post arthroscopy, and medication induced gastritis. Past treatments were physical therapy, epidural steroid injections, Synvisc injection to the right knee, 4 trigger point injections on 04/25/2014, 4 trigger point injections on 05/23/2014, and 4 trigger point injections on 06/20/2014. Diagnostic studies were an MRI of the right knee and an MRI of the lumbar spine. The MRI of the spine revealed in L1-2 there was a 1 to 2 mm posterior disc protrusion with hypertrophic facet changes. At L2-3 there were hypertrophic facet changes. At L3-4 there were mild hypertrophic facet changes. At L4-5 there was a 2 mm central disc protrusion with hypertrophic facet changes. L5-S1 revealed evidence of posterior fusion and metallic orthopedic prosthesis in place, an interbody prosthesis was present, a first to second degree spondylolisthesis at the L5-S1 was present with severe spondylolisthesis and hypertrophic facet changes with mild lateral recess stenosis bilaterally. EMG study of the lower extremities in 2009 revealed bilateral L5-S1 radiculopathy. Surgical history was 2 right knee arthroscopy surgeries, a 360 fusion procedure of the lumbar spine and posterior spinal fusion at L5-S1. Physical examination on 06/20/2014 revealed complaints of low back pain that radiated down to both lower extremities. There was still some axial low back pain associated with myospasms. It was reported the injured worker had trigger point injections 2 weeks prior with "very good" benefit of greater than 50%. The injured worker reported he occasional takes Fexmid, especially in the evenings in order to sleep better and function throughout the day. The injured worker uses a single point cane and he has a CTI brace on the right knee. Examination of the lumbar spine

revealed tenderness to palpation on the posterior lumbar musculature bilaterally with significant muscle rigidity along the lumbar paraspinal muscles. There was a decreased range of motion. Forward bend was measured to around 4 inches above the knees, and extension was limited to 10 degrees. Deep tendon reflexes were 1/4 in the patella and absent in the Achilles bilaterally. Straight leg raise was positive bilaterally in the sitting position at 60 degrees. Sensory examination for sensation was decreased along the posterolateral thigh and posterolateral calf bilaterally. Medications reported were Anaprox, Fexmid, Norco, and Prilosec. The treatment plan was for a referral to an orthopedic surgeon for the right knee and acupuncture treatment. The rationale was not submitted. The Request for Authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture for lower back area quantity 12: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, and it is recommended as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The time to produce functional improvement is 3 to 6 treatments, and acupuncture treatments may be extended if functional improvement is documented, including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. Prior acupuncture treatment functional outcomes were not reported. The request exceeds the recommended 3 to 6 visits. Therefore, the request for acupuncture for lower back area quantity 12 is not medically necessary and appropriate.

Retrospective request for Prilosec 20 mg quantity 30, dispensed on 06/20/14: 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 NSAIDs Page(s): 68-69.

Decision rationale: According to the MTUS Guidelines, "Clinicians should determine if the patient is at risk for gastrointestinal events which include age greater than 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at

intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use over one year has been shown to increase the risk of hip fracture. Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary." Although the injured worker has reported relief from the medication, the request does not indicate a frequency for the medication. Therefore, the retrospective request for Prilosec 20 mg quantity 30, dispensed on 06/20/14 is not medically necessary and appropriate.

Trigger point injection to the lumbar muscle: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 121, 122.

Decision rationale: The California MTUS recommends trigger point injections for myofascial pain syndrome and they are not recommended for radicular pain. Criteria for the use of Trigger point injections include documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; Symptoms have persisted for more than three months; Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; Radiculopathy is not present (by exam, imaging, or neuro-testing); and there are to be no repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement. Additionally they indicate that the frequency should not be at an interval less than two months. Injections were given on 04/25/2014, 05/23/2014 and 06/20/2014. The medical guidelines state 6 weeks of pain relief should be documented. Radiculopathy should not be present by exam, imaging, or neuro-testing. It was not documented that the injured worker had 6 weeks of pain relief greater than 50%. Also, radiculopathy symptoms were present. Examination did not report a "twitch" response. Therefore, the request for a trigger point injection to the lumbar muscle is not medically necessary and appropriate.