

Case Number:	CM14-0166253		
Date Assigned:	10/13/2014	Date of Injury:	05/22/2012
Decision Date:	11/24/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/07/2014

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 Internal Medicine and is licensed to practice in Maryland. 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 employee was a 69 year old male who sustained an industrial injury on 05/22/12. The clinical note from 09/04/14 was reviewed from utilization review letter. He had pain in the low back with radicular symptoms to the lower extremities involving the bilateral posterior thigh and calf, worse on the right side. He also had bilateral knee pain. He had tenderness over the midline of the lumbar spine as well as along the bilateral lumbosacral areas. Reflexes were diminished in the patellar and Achilles tendons. Slump test was positive bilaterally and lumbar extension caused pain over the facet joints to the left and right. Lumbar range of motion was a flexion at 50 degrees, extension, tilting and rotation was 30 degrees. The claimant had a lumbar epidural steroid injection on 08/05/13 with about 80-90% improvement in symptoms which lasted for more than three months. Treatment plan included lumbar epidural steroid injection, motorized cold therapy unit for post injection treatment, refill of Gabapentin, Naprosyn, analgesic cream, Tizanidine, Omeprazole, re-evaluation and follow-up. The clinical note from 07/10/14 was reviewed. Subjective complaints included low back pain with radicular symptoms to bilateral lower extremities involving bilateral posterior thigh and calf worse on right side and bilateral knee pain. Objective findings included tenderness to touch over the midline of lumbar spine and bilateral lumbo sacral area. He also had diminished deep tendon reflexes bilaterally in patellar tendon and Achilles tendon. Slump test positive bilaterally and lumbar extension caused pain over the facet joints to the left and right. He had diminished range of motion of the lumbar spine as follows, flexion 50, extension 30, right tilt 30, left tilt 30, right rotation 30 and left rotation 30. Diagnoses included lumbar spine spondylosis at the level L4-L5, L5-S1 bilateral facet arthropathy, lumbar spine degenerative disc disease with moderate to severe central stenosis and bilateral neuroforaminal stenosis of L4-L5 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection right L4-L5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: According to Chronic Pain Medical Treatment guidelines, epidural steroid injections are recommended for radicular pain documented by physical examination and corroborated by electrodiagnostic and/or imaging studies, initially unresponsive to conservative treatment and no more than one interlaminar level should be injected at one setting. In therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. The employee had pain radiating down bilateral lower extremities with diminished range of motion of spine and decreased patellar and ankle reflexes. There were no imaging or electrodiagnostic studies to corroborate radiculopathy. Also the clinical note provided for review doesn't describe the results of his prior epidural steroid injection. Hence, the request for epidural steroid injections is not medically necessary and appropriate.

Lumbar epidural steroid injection left L4-L5 and bilateral L5-S1 QTY: 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: According to Chronic Pain Medical Treatment guidelines, epidural steroid injections are recommended for radicular pain documented by physical examination and corroborated by electrodiagnostic and/or imaging studies, initially unresponsive to conservative treatment and no more than one interlaminar level should be injected at one setting. In therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. The employee had pain radiating down bilateral lower extremities with diminished range of motion of spine and decreased patellar and ankle reflexes. There were no imaging or electrodiagnostic studies to corroborate radiculopathy. Also the clinical note provided for review doesn't describe the results of his prior epidural steroid injection. Hence the request for epidural steroid injections is not medically necessary and appropriate.

Purchase of motorized cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Naprosyn 550mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 78-79.

Decision rationale: According to Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended as an option in chronic low back pain for short-term symptomatic relief. Guidelines don't endorse long term use. The employee's records demonstrate complaints of chronic low back pain and knee pain. There is no relevant documentation about the need for ongoing NSAIDs given the lack of functional improvement. The request for naproxen 550 mg #60 is not medically necessary and appropriate.

Compound analgesic cream 120g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

Decision rationale: According to MTUS, Chronic Pain Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The request was for compound analgesic cream. Given the lack of information about the ingredients in the cream, the request for compound analgesic cream is not medically necessary or appropriate.

Tizanidine 4mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: According to MTUS guidelines, Tizanidine is a muscle relaxant with demonstrated efficacy for back pain. The records provided for review revealed no clear improvement in pain scales with use of Tizanidine. Hence the request for Tizanidine is not medically necessary or appropriate.

Omeprazole 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton pump inhibitors Page(s): 68.

Decision rationale: Employee was being treated for cervical, lumbar disc disease and also for shoulder pain. The request is for Prilosec which is a proton pump inhibitor. According to the chronic pain guidelines, proton pump inhibitors are indicated in the treatment of NSAID-induced dyspepsia. In addition proton pump inhibitors can be used as a prophylaxis for patients with underlying cardiovascular disease and with high risk factors for gastrointestinal events. The employee had no documented symptoms of dyspepsia and was not on multiple NSAIDs or anticoagulants. The request for Omeprazole was not medically necessary or appropriate.