MAXIMUS Federal Services

Case Number:	CM14-0176886		
Date Assigned:	10/30/2014	Date of Injury:	04/22/2005
Decision Date:	12/05/2014	UR Denial Date:	10/18/2014
Priority:	Standard	Application Received:	10/24/2014

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 New York. 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 patient is a 64 year old male with a date of injury of 04/22/2005. He has chronic low back pain. On 10/08/2013 and on 01/29/2014 a urine drug test was negative for opiate despite being prescribed Norco. On 01/21/2014 he had a right radiofrequency ablation of L5, S1 for lumbar spondylosis and a medial branch block at L3, L4. On 01/28/2014 he was taking Celebrex and Prilosec. He stopped the Norco after the block/ablation. There was no loss of coordination. Motor exam was normal. Reflexes were normal. Sensory exam was normal. On 02/04/2014 he had the same procedure as on 01/21/2014 but this time on the left side. On 03/25/2014, 05/20/2014 and on 07/17/2014 during the office visit he had no pain. Norco, Celebrex and Prilosec were refilled. Motor, sensory and reflex exams were normal. On 10/13/2014 motor strength, sensation and reflexes were normal. Pain was 2/10. There were no focal neurologic changes. He had back, neck, knee and lower leg pain. He was alert. There was no loss of coordination. It was not until the discussion (after the history and review of systems which was negative) that the provider noted that there were problems with balance and dizziness. There was no documentation of nystagmus on exam.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 VAT (Vestibular Autorotational Test): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Harrison's Principles of Internal Medicine, 18th Edition. 2011.

Decision rationale: MTUS, ACOEM Chapter 12, Low Back Complaints do not mention this test. ODG 2014, Pain also does not mention this testing. The history and review of systems in all of the notes in 2014 do not mention any difficulty with dizziness or balance. In fact each office visit noted no difficulty with coordination. The history of the dizziness was not documented as standard of care. There was no documentation of any dizziness or balance problems with change in position. There is insufficient documentation to substantiate the medical necessity of this requested testing and there is no relation to his back complaints with any motor, sensory, coordination deficit or focal finding on examination. Therefore this request is not medically necessary.

Celebrex 200mg # 30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GuidelinesNSAIDS Page(s): 67-68.

Decision rationale: Specific recommendations: Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective that acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007). There is no documentation of osteoarthritis. There was no documentation of a failure of treatment with acetaminophen which does not have the cardiac, tissue healing or GI adverse effects of NSAIDS. Also, NSAIDS are recommended for short term use. Therefore, this request is not medically necessary.

Prilosec 20mg #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS GI Symptoms and Cardiovascular Risk Page(s): 68-69.

Decision rationale: Clinicians should weight the indications for NSAIDs against both GI and cardiovascular riskfactors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations 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 (200g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary.Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. The patient is not 65 years of age or older, has no documentation of GI bleed or peptic ulcer disease and does not have a high risk of bleeding. Therefore, this request is not medically necessary.