

Case Number:	CM14-0023708		
Date Assigned:	06/13/2014	Date of Injury:	09/20/2008
Decision Date:	09/25/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	02/25/2014

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 Occupational and Preventative Medicine, 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 records presented for review indicate that this 48 year-old female was reportedly injured on 9/20/2008. The mechanism of injury is noted as a slip and fall. The most recent progress note dated 10/10/2013, indicates that there are ongoing complaints of low back pain that radiates down the right lower extremity. Physical examination demonstrated gait and station midposition without abnormalities; motor strength: right hip flexors 4/5, right hamstring 4/5, right quadriceps 4/5, otherwise strength 5/5; tenderness to left lumbar paraspinous area; straight leg raise is mildly positive; patella reflexes 0/4; decrease sensation to light touch in right foot; positive FABER maneuver left; positive Gainslen's maneuver left; positive Patrick's maneuver left. MRI of the lumbar spine demonstrates mild facet arthropathy at L3/4; moderate facet arthropathy, thickening of the ligamentous flavum, broad based disc bulge resulting in mild to moderate canal and foraminal stenosis at L4/5, moderate facet arthropathy with a left-sided disc bulge resulting in mild left foraminal narrowing at L5/S1. Previous treatment includes chiropractic care, massage therapy and medications to include: Cymbalta, Flector patch, Naproxen and Norco and Zanaflex. A request had been made for a dorsal rami diagnostic block (levels to be determined by anesthesiologists) and was not certified in the utilization review on 2/20/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

DORSAL RAMI DIAGNOSTIC BLOCK (LEVELS TO BE DETERMINED BY ANESTHESIOLOGIST): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): (electronically cited).

Decision rationale: ACOEM Guidelines do not support dorsal rami diagnostic blocks for radicular pain syndromes. One diagnostic injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation, or associated with lumbar rigidity and is not alleviated with other conservative treatments. The request is for an unspecified level(s) and the patient has low back pain that radiates down the leg. Furthermore, there is no documentation of previous physical therapy available. As such, the request is not medically necessary.

12 PHYSICAL THERAPY VISITS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE GUIDELINES Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: As outlined in the ACOEM Guidelines, a course of physical therapy has no specific recommendation. As noted in the MTUS, after one or two sessions a transition to a home exercise protocol is supported. There is no clear evidence of an acute exacerbation or efficacy of any prior physical therapy. Therefore, there is insufficient clinical information presented to support this request for twelve physical therapy visits. The medical necessity has not been established.

ZANAFLEX 4 MG 1 2X/DAY X 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63,65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha 2-adrenergic agonist that is Food and Drug Administration (FDA) approved for management of spasticity. It is unlabeled for use in low back pain. Muscle relaxants are only indicated as 2nd line options for short-term treatment. It appears that this medication is being used on a chronic basis which is not supported by MTUS treatment guidelines. Therefore, this medication is not medically necessary.

BUTRANS PATCH: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BUPRENORPHINE Page(s): 26-27.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 26-27.

Decision rationale: MTUS Guidelines recommend Buprenorphine (Butrans) for the treatment of opiate addiction and as an option for chronic pain, especially after a detoxification program. Review of the available medical records fails to document that the injured employee meets the criteria for the use of this medication. As such, this request for Butrans patches is not medically necessary.

NORCO 10-325 #250 TAKE 1 9X/DAY AS NEEDED: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

Decision rationale: As outlined in the MTUS Guidelines, this medication is a short acting opioid indicated for breakthrough pain. The progress notes presented for review indicate that this is for a constant, chronic an indefinite application. Furthermore, there is no data presented to suggest that this medication has any efficacy or utility in terms of increased functionality or decreased symptomology. As such, the intended goals are not met and the utility has not been objectified. Therefore, the request is not medically necessary.

SPRINTEC 1 PACK: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/sprintec.html>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:<http://www.ncbi.nlm.nih.gov/pubmed/11727171>.

Decision rationale: This medication is a birth-control pill. There is no data presented to suggest the indications for or a desire to use such a medication. Therefore, based on this complete lack of clinical information, the medical necessity cannot be established for the request.