

Case Number:	CM14-0024968		
Date Assigned:	06/11/2014	Date of Injury:	07/09/2012
Decision Date:	07/31/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	02/27/2014

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, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 28-year-old male with a 7/9/12 date of injury, and status post left L4-L5 microdiscectomy 11/8/12. At the time (2/25/14) of request for authorization for Ativan tablet 1mg 1 tablet at bedtime qty: 60.00, Lumbar MRI without contrast qty: 1.00, Lumbar MRI with contrast qty: 1.00, there is documentation of subjective (back pain and left leg radicular pain resulting in impaired gait) and objective (bilateral no ecchymosis, tenderness, lumbar range of motion diminished (flexion, extension restricted by pain), straight leg raise negative both sitting and supine on right and positive on left, 5-/5 motor strength of knee flexion and extension and plantar flexion, left scar area most tender, lower extremity exam within normal limits, normal deep tendon reflexes, normal motor function) findings, imaging findings (Lumbar Spine MRI (2/25/13) report revealed transitional lumbosacral vertebrae designated as S1 in this report, decreased size of the extruded disc at L5-S1, no new spinal canal stenosis, abnormality in the vicinity of the left S1 nerve root at the surgical level present which may represent nerve root inflammation or scar tissue, less likely is residual disc material), current diagnoses (lumbar degenerative disc disease, myofascial pain, postlaminectomy syndrome, sciatica, low back pain, and arthritis of the back), and treatment to date (medications (including Ativan since at least 11/6/13)). Regarding Ativan tablet 1mg 1 tablet at bedtime qty: 60.00, there is no documentation of the intention to treat over a short course. Regarding Lumbar MRI without contrast qty: 1.00, Lumbar MRI with contrast qty: 1.00, there is no documentation of a diagnosis/condition for which a repeat study is indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

ATIVAN TABLET 1MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that benzodiazepines are not recommended for long-term and that most guidelines limit use to 4 weeks. Within the medical information available for review, there is documentation of diagnoses of lumbar degenerative disc disease, myofascial pain, postlaminectomy syndrome, sciatica, low back pain, and arthritis of the back. However, given documentation of records reflecting prescriptions for Ativan since at least 11/6/13, there is no documentation of the intention to treat over a short course (up to 4 weeks). Therefore, based on guidelines and a review of the evidence, the request for Ativan tablet 1mg 1 tablet at bedtime qty: 60.00 is not medically necessary.

LUMBAR MRI WITHOUT CONTRAST QTY: 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Other Medical Treatment Guidelines: Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of lumbar degenerative disc disease, myofascial pain, postlaminectomy syndrome, sciatica, low back pain, and arthritis of the back. In addition, there is documentation of imaging findings (Lumbar spine MRI identifying transitional lumbosacral vertebrae designated as S1 in this report, decreased size of the extruded disc at L5-S1, no new spinal canal stenosis, abnormality in the vicinity of the left S1 nerve root at the surgical level present which may represent nerve root inflammation or scar tissue, less likely is residual disc

material. However, there is no documentation of a diagnosis/condition for which a repeat study is indicated (To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for Lumbar MRI without contrast qty: 1.00 is not medically necessary.

LUMBAR MRI WITH CONTRAST QTY: 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Other Medical Treatment Guidelines: Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of lumbar degenerative disc disease, myofascial pain, postlaminectomy syndrome, sciatica, low back pain, and arthritis of the back. In addition, there is documentation of imaging findings (Lumbar spine MRI identifying transitional lumbosacral vertebrae designated as S1 in this report, decreased size of the extruded disc at L5-S1, no new spinal canal stenosis, abnormality in the vicinity of the left S1 nerve root at the surgical level present which may represent nerve root inflammation or scar tissue, less likely is residual disc material. However, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for Lumbar MRI with contrast qty: 1.00 is not medically necessary.

