

Case Number:	CM14-0026080		
Date Assigned:	06/13/2014	Date of Injury:	01/08/2009
Decision Date:	07/22/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	02/28/2014

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 Medicine and is licensed to practice in Texas. 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 57 year old male who sustained an injury to his low back on 01/08/09 due to lifting a heavy weight. The injured worker suddenly developed low back pain with radiation into the left lower extremity. Per the submitted clinical records, the injured worker has chronic low back pain. The injured worker is further noted to have osteoarthritis involving the left knee for which he has previously been approved for a left total knee arthroplasty. Records indicate that the injured worker has undergone an L4-5 epidural steroid injection without benefit and more recently on 01/24/14 he underwent a left hip injection. The serial clinical records indicate that the injured worker is maintained on opiates. The injured worker has undergone a urine drug screen on 11/18/13 and noted to be compliant. It is reported that without medications the injured worker's pain level is 10/10 on the visual analog scale, with medications the pain level is 4/10 on the visual analog scale. The injured worker is noted to have functional improvements which allow him to participate in a home exercise program and he acts as a volunteer coach. The records indicate that the injured worker has undergone lumbar radiographs on 02/06/14. This study noted multi-level degenerative disease. This note documented clinical indications for the performance of these radiographs. The record contains a utilization review determination dated 02/21/14 in which a prospective request for radiographs of the lumbar spine, 6 physical therapy sessions for sacroiliac joint dysfunction, a sacroiliac joint belt, a prescription refill of Celebrex 100mg #60 with 2 refills, and Lunesta 3mg #30 with 2 refills was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

PROSPECTIVE REQUEST FOR 1 X-RAY OF THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306.

Decision rationale: The prospective request for an x-ray of the lumbar spine is not supported as medically necessary. The submitted clinical records indicate that the injured worker has a chronic history of low back pain. The injured worker has previously undergone lumbar radiographs as well as an MRI of the lumbar spine. The record provides no red flags which would establish that there has been a substantive change in the injured worker's condition that would establish the medical necessity for repeat x-rays of the lumbar spine. The request is not medically necessary.

PROSPECTIVE REQUEST FOR 6 PHYSICAL THERAPY SESSIONS FOR SACROILIAC DYSFUNCTION: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Hip and Pelvis, Physical Therapy.

Decision rationale: The prospective request for 6 physical therapy sessions for sacroiliac joint dysfunction is not supported as medically necessary. Per the most recent physical examination, the injured worker was noted to have sacroiliac joint tenderness. However, there are no other documented findings of sacroiliac joint dysfunction and therefore the diagnosis not established. As such, the medical necessity for 6 sessions of physical therapy would not be supported.

PROSPECTIVE REQUEST FOR 1 SACROILIAC BELT: 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) Hip and Pelvis (Acute and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Hip and Pelvis, Sacroiliac Belt.

Decision rationale: The prospective request for 1 sacroiliac belt is not supported as medically necessary. As previously stated, the submitted clinical records fail to establish a diagnosis of sacroiliac joint dysfunction and as such, the request for a sacroiliac joint belt would not be established as medically necessary.

PROSPECTIVE REQUEST FOR 1 PRESCRIPTION OF CELEBREX 100MG #60 WITH 2 REFILLS: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 67-73. Decision based on Non-MTUS Citation (ODG) Pain Chapter, Celebrex.

Decision rationale: The prospective request for 1 prescription of Celebrex 100mg #60 with 2 refills is recommended as medically necessary. The submitted clinical records indicate that the injured worker has osteoarthritis involving the knee and hip as well as substantive degenerative changes on imaging studies of the low back. Records indicate that the injured worker receives benefit from this medication and as such, the continued use would be clinically indicated and is supported by Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines. The request is medically necessary.

PROSPECTIVE REQUEST FOR 1PRESCRIPTION OF LUNESTA 3MG #30 WITH 2 REFILLS: 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) Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Pain Chapter, Insomnia treatment.

Decision rationale: The prospective request for 1 prescription of Lunesta 3mg #30 with 2 refills is not supported as medically necessary. The submitted clinical records indicate that the injured worker has a chronic history of low back pain and joint dysfunction and subsequently suffers from sleep disturbance as a result. Current evidence based guidelines do not support the chronic use of sleep aids. These medications are recommended to be used for a 2-3 week period until normalization of sleep and then subsequently discontinued. The record does not provide any additional data which suggests that the injured worker has undergone a detailed evaluation for his reported sleep disturbance. As such, the continued use of this medication would not be supported as medically necessary.