

Case Number:	CM14-0027462		
Date Assigned:	06/13/2014	Date of Injury:	04/21/2005
Decision Date:	07/16/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	03/04/2014

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 Family Medicine and is licensed to practice in Arizona. 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 36 year old male with a date of injury on 4/21/2005. Diagnoses include sinus tarsi syndrome, plantar fasciitis, Achilles tendonitis, posterior tibial tendonitis, and reflex sympathetic dystrophy of the lower limb. Subjective complaints are of pain in the right posterior heel, which is tearing and throbbing, pain at the lateral aspect of the right ankle, and low back pain. Physical exam shows tenderness over the right ankle, and right lower extremity, and severe tenderness over the heel and peroneal tendon. Lumbar spine shows tenderness to palpation, and a positive straight leg raise test. Medications include lidoderm, Neurontin, lidocaine, flexeril, Lunesta, Norco, and oxycodone. Documentation indicates that the patient has a spinal cord stimulator that needs a new battery. Records also indicate that patient had prior epidural steroid injections, but does not include duration or extent of efficacy.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR EPIDURAL STEROID INJECTIONS AT LEVELS OF L5-S1 AND S1-S2:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS, ESI Page(s): 35-41; 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, ESI.

Decision rationale: CA MTUS notes that the purpose of epidural steroid injection (ESI) is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. For consideration of injections, radiculopathy must be evident on imaging and/or electrodiagnostic studies. While for diagnostic purposes, a maximum of two injections can be performed if there is inadequate response to the first block. An inadequate response (ODG ESI chapter) of <30% would not warrant a second ESI. For therapeutic injections, repeat blocks should be based on continued objective pain relief and functional improvement, including at least 50% improvement for 6 to 8 weeks. This patient had previous injections for which efficacy was not documented in the records. Therefore, the request for Lumbar Epidural Steroid Injections at the levels of L5-S1 and S1-S2 is not medically necessary and appropriate.

NEURONTIN 600MG #150 WITH 5 REFILLS: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AEDs, CRPS Page(s): 16, 41.

Decision rationale: CA MTUS indicates that gabapentin is an anti-seizure medication is recommended for neuropathic pain. It is also indicated that gabapentin is useful in the treatment of complex regional pain syndrome/reflex sympathetic dystrophy. Review of the submitted medical records indicates that the patient has reflex sympathetic dystrophy which is a guideline recommended diagnosis for the use of gabapentin. Therefore, the use of gabapentin is consistent with guidelines and is medically necessary.

FLEXERIL 10MG # 90 WITH 5 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Fexamid).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: CA MTUS guidelines indicate that the use of cyclobenzaprine should be used as a short term therapy, and the effects of treatment are modest and may cause adverse effects. This patient had been using muscle relaxer chronically which is longer than the recommended course of therapy of 2-3 weeks. Furthermore, muscle relaxers in general show no benefit beyond NSAIDS in pain reduction of which the patient was already taking. There is no evidence in the documentation that shows evidence of muscle spasm or that the patient

experienced improvement with the ongoing use of cyclobenzaprine. Due to clear guidelines suggesting cyclobenzaprine as short term therapy and no clear benefit from adding this medication the requested prescription for Flexeril 10mg (cyclobenzaprine) #90 with 5 refills is not medically necessary.

SCS (SPINAL CORD STIMULATOR) PERMANENT REPLACEMENT, FOR RIGHT SIDE: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator (SCS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS spinal cord stimulators Page(s): 38.

Decision rationale: CA MTUS recommends spinal cord stimulators (SCS) only after careful counseling and patient identification, when less invasive procedures have failed, and only used following a successful temporary trial. This patient has a pre-existing SCS which was noted to be very helpful for the patient's symptoms. Documentation indicates that the battery needs to be replaced. Therefore, due to ongoing efficacy of this device, the request of SCS (Spinal Cord Stimulator) permanent replacement, for right side is medically necessary and appropriate.