

Case Number:	CM14-0052334		
Date Assigned:	08/08/2014	Date of Injury:	03/02/1998
Decision Date:	09/16/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	04/21/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 59-year-old male was reportedly injured on March 2, 1998. The mechanism of injury was not listed in the records reviewed. The most recent progress note, dated April 3, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated the patient in less distress with a nonantalgic gait pattern, a nearly full range of motion in all planes and there was moderate paravertebral lumbar muscle spasm as well as tenderness to palpation. Diagnostic imaging studies objectified a mild disc lesion on MRI at L5-S1. Previous treatment included multiple medications, physical therapy and pain management interventions. A request was made for physical therapy and multiple medications and was denied in the pre-authorization process on April 9, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, 6 Sessions, for the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-Low Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: When noting the date of injury, the injury sustained, the multiple interventions completed, and multiple episodes of physical therapy, there is no data presented to suggest that a home exercise protocol emphasizing overall fitness, conditioning and achieving ideal body weight cannot be accomplished with such exercises. It is noted that passive therapy can provide short term relief in the early phase of the injury. Clearly, that aspect has passed. As such, based on the limited clinical rationale presented for review, this The request is not medically necessary and appropriate.

Prednisone Burst dose 10mg 2 pills 3 times daily.: 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 Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low back chapter updated July 2014.

Decision rationale: The recent progress note indicates that a course of corticosteroids had been recently completed. While noting that corticosteroids are supported in the ODG, limited circumstances were noted for acute radicular pain. Based on the physical examination reported and noting that the radiculopathy dates back a number of years, this is at best a chronic situation. As such, given the current completion, the lack of a significant acute radiculopathy, there is insufficient clinical data presented to support this request. It should be noted that the issue of more MTUS guidelines do not address. Therefore, this request is not medically necessary and appropriate.

Gabapentin 600mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20,49.

Decision rationale: When noting the injury sustained, the findings noted on MRI and on electrodiagnostic studies, there is indication of a radiculopathy. This neuropathic lesion can be addressed satisfactorily with this medication. As such, The request is not medically necessary and appropriate.

Acetaminophen 500mg #30: Upheld

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

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

Decision rationale: Acetaminophen is recommended in the MTUS; however, there needs to be some clarification about the possibility of liver disease. Therefore, when noting that there has not been any objectified improvement in the overall clinical situation, the efficacy of this medication is not established. Consequently, when combining the side effect profile with the lack of functional improvement, the request is not medically necessary and appropriate.

Nabumetone 500mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72.

Decision rationale: Relafen is a nonselective, non-steroidal anti-inflammatory medication with an indication for osteoarthritis per MTUS treatment guidelines. When noting the claimant's clinical presentation and current diagnosis, there is no clinical indication for the use of this medication. As such, this The request is not medically necessary and appropriate.

Norflex 100mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65.

Decision rationale: This drug is similar to Diphenhydramine but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to Analgesic and Anticholinergic properties. However, after number of years, there are still physical examination findings noting muscle spasm and tenderness to palpation. Therefore, the efficacy of this medication hasn't clearly been established and is not presented in this case. Therefore, The request is not medically necessary and appropriate.