MAXIMUS Federal Services

Case Number:	CM14-0069738		
Date Assigned:	08/08/2014	Date of Injury:	07/01/1992
Decision Date:	09/18/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	05/14/2014

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 Anesthesiologist and Pain Medicine, and is licensed to practice in Florida. 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 68-year-old female who reported an injury on 08/08/1996. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to her low back. The injured worker's treatment history included low back surgery, physical therapy, acupuncture, and epidural steroid injections. The injured worker developed chronic pain that was managed with multiple medications. The injured worker was evaluated on 04/04/2014 and it was noted that the injured worker had chronic low back pain radiating into the right lower extremity. It was reported that the injured worker was out of medications, and that medications helped improve function and ability to continue to function. It was noted that the injured worker's pain level was a 7/10 at that appointment. Physical findings included decreased range of motion secondary to pain with decreased sensation in the L4, L5 and S1 dermatomal distribution with a positive right side straight leg raising test. The injured worker had 4/5 strength of the right sided deep tendon reflexes. The injured worker's medications included Lidoderm patch, ketamine cream, baclofen 10 mg, gabapentin 200 mg, hydrocodone/APAP 10/325 mg, pantoprozole, Xanax, Paxil, Flonase, hydrocortisone, loratadine and nucative tablets. The injured worker's diagnoses included syndrome postlaminectomy lumbar and lumbar disc displacement without myelopathy. The injured worker's treatment plan included a prescription of Lidoderm, baclofen, gabapentin, hydrocodone/APAP 10/325 mg and pantoprozole. It was also noted that the injured worker required a lumbar back brace and heating pad to assist with worsening pain. It was noted that the injured worker was participating in a home exercise program, and was advised to continue. It was also noted that the injured worker would undergo a urine drug screen to monitor for aberrant behavior. A letter of appeal dated 05/21/2014 documented that the injured worker's medications, an MRI and durable medical equipment received adverse determinations. It was noted that the MRI was not authorized due to a lack of

documentation of a significant change in symptoms to warrant an additional imaging study. It was noted on 05/01/2014 that the injured worker's pain was progressive in nature. It was noted that the injured worker's last MRI was done in 2007, and due to deterioration in her condition and progressive neurological symptoms and progressive pain, an updated MRI was being requested. It was noted that the injured worker's lumbar brace and back rest for her chair and her heating pad had received an adverse determination, as there was lack of justification to support the request. The letter of appeal dated 05/01/2014 indicated that the injured worker required this equipment to assist with progressive pain, and to provide comfort to further allow the injured worker to participate in activities of daily living while sitting. It was noted that the requested Lidoderm had received an adverse determination, as there was a lack of documentation that the injured worker had failed to respond to oral medications. It was noted on 05/01/2014 that the injured worker's oral medications made her drowsy, and that the injured worker had had significant side effects resulting from the use of gabapentin. It was noted that the request for Protonix received an adverse determination, as there was a lack of documentation to support that the injured worker had failed to respond to first line medications. On 05/01/2014 it was noted that the injured worker had failed to respond to Prilosec. The services were again requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Lumbar Spine with and without contrast, QTY: 1: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Low Back Procedure Summary last updated 03/18/14 - MRI's.

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, MRI.

Decision rationale: The requested MRI of the Lumbar Spine with and without contrast is medically necessary and appropriate. The American College of Occupational and Environmental Medicine do not address repeat imaging. Official Disability Guidelines recommend repeat MRIs if there is a significant change in the injured worker's clinical presentation or documentation of progressive neurological deficits. The clinical documentation submitted for review does support that the injured worker has progressive neurological deficits, and that her condition is deteriorating. Therefore, an additional MRI would assist in treatment planning. As such, the requested MRI of the Lumbar Spine with and without contrast is medically necessary and appropriate.

Lumbar Back Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Low Back Procedure Summary last updated 03/18/2014 - Lumbar Supports.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

Decision rationale: The requested lumbar back brace is not medically necessary or appropriate. The clinical documentation does indicate that the injured worker has progressive pain complaints and that the back brace would be used to assist with pain relief. The American College of Occupational and Environmental Medicine do not support the use of a back brace for acute and chronic back pain. Official Disability Guidelines do not recommend the use of a back brace as a treatment for pain. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested lumbar back brace is not medically necessary or appropriate.

Back Rest for Chair: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment CG-DME-10: DME.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg chapter, Durable Medical Equipment (DME).

Decision rationale: The requested Back rest for Chair is medically necessary and appropriate. California Medical Treatment Utilization Schedule does not specifically address this request. Official Disability Guidelines recommend durable medical equipment when it is customarily and primarily used to serve a medical purpose. The clinical documentation does indicate that the injured worker has progressive pain complaints, and that the back rest would be used to assist with pain relief and allow the injured worker to sit for longer periods of time to participate in activities of daily living. Therefore, a Back Rest for Chair would be supported in this clinical situation. As such, the requested Back Rest for Chair is medically necessary and appropriate.

Heating Pad for Lumbar Spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Low Back Procedure Summary last updated 03/18/2014 - Heat therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

Decision rationale: The requested Heating Pad for Lumbar Spine is medically necessary and appropriate. The American College of Occupational and Environmental Medicine recommend hot and cold applications to assist with pain control in conjunction with an active therapeutic program. The clinical documentation submitted for review does indicate that the injured worker is participating in a home exercise program that would benefit from the application of a heating pad. It is noted within the documentation that the injured worker has progressive pain

complaints. A heating pad would assist with pain control. As such, the requested Heating Pad for Lumbar Spine is medically necessary and appropriate.

Lidoderm 5% patch #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents (NSAIDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Lidoderm 5% patch #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of a Lidoderm patch when oral anticonvulsants are not tolerated or ineffective. The clinical documentation submitted for review does indicate that the injured worker has failed to respond to a trial of gabapentin. It is noted that the injured worker has uncontrolled side effects resulting from the use of that medication. Therefore, continued use would be supported in this clinical situation. However, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Lidoderm 5% patch #60 is not medically necessary or appropriate.

Hydrocodone/APAP 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic trial of opioids, opioids for chronic pain in general conditions.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The requested Hydrocodone/APAP 10/325mg #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior with urine drug screens. However, the clinical documentation submitted for review does not provide any evidence of a quantitative assessment of pain relief to support continued use of this medication. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Hydrocodone/APAP 10/325mg #120 is not medically necessary or appropriate.

Pantoprazole-Protonix 20mg #4: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Pain Procedure Summary last updated 03/18/2014 - Proton Pump Inhibitors (PPI's).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The requested Pantoprazole-Protonix 20mg #4 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommended the ongoing use of gastrointestinal protectants be supported by documentation of risk factors contributing to gastrointestinal disturbances related to medication usage. Additionally, this medication is specifically identified as a second line treatment by Official Disability Guidelines. The clinical documentation submitted for review does indicate that the injured worker failed an attempt to relief symptoms with Prilosec. It is also noted that he injured worker does have gastric upset with medication usage. Therefore, continued use of this medication would be supported in this clinical situation. However, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Pantoprazole-Protonix 20mg #4 is not medically necessary or appropriate.