MAXIMUS Federal Services

Case Number:	CM14-0129076		
Date Assigned:	09/10/2014	Date of Injury:	09/27/2006
Decision Date:	03/23/2015	UR Denial Date:	08/04/2014
Priority:	Standard	Application Received:	08/13/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Illinois, Texas
Certification(s)/Specialty: Internal Medicine, Occupational Medicine

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 60-year-old woman that injured her low back and left hip on Sept 27, 2006. Her pain is 0/10 with medications and 5/10 without medications. She had a sacral lateral branch block with temporary pain relief of 8 weeks in 2013. On June 27, 2014, she complained of difficulties with activities of daily living, loss of range of motion, difficulty walking/running and stiffness. Her exam shows her back and hip range of motion is severely restricted and positive bilateral straight leg raise test. Bilateral lower extremity sensation is abnormal with weakness and paresthesias. At the office visit on July 28, 2014 the worker complained of low back pain and left hip pain at 6/10 without medications and 1/10 with medications. The physical exam is essentially the same as the June 27, 2014 office visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4-5 transforaminal epidural steroid injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: Per Chronic Pain Medical Treatment Guidelines, the purpose of epidural steroid injections 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. Epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). This injured worker has complaints of back pain with radiculopathy and an exam that is consistent with these complaints. However, as stated above, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. This confirmation is not documented. Therefore the request for left L4-5 transforaminal epidural steroid injection is not medically necessary.

Right L4-5 transforaminal epidural steroid injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: The purpose of epidural steroid injections 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. Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). This injured worker has complaints of back pain with radiculopathy and an exam that is consistent with these complaints. However, as stated above, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. This confirmation is not documented. Therefore the right L4-5 transforaminal epidural steroid injection request is not medically necessary.

Left L5-S1 transforaminal epidural steroid injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: This injured worker has complaints of back pain with radiculopathy and an exam that is consistent with these complaints. However, as stated above, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. This confirmation is not documented. Therefore the left L5-S1 transforaminal epidural steroid injection request is not certified.

Right L5-S1 transforaminal epidural steroid injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: This injured worker has complaints of back pain with radiculopathy and an exam that is consistent with these complaints. However, as stated above, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. This confirmation is not documented. Therefore the right L5-S1 transforaminal epidural steroid injection request is not medically necessary.

Cetirizine 10 mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Adkinson: Middleton's Allergy: Principles and Practice, 6th ed. Chapter 51

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 1. Gupta LK, Agarwal N, Khare AK, Mittal A. Fixed drug eruption to levocetirizine and cetirizine. Indian J Dermatol. 2014 Jul;59(4):411-3. 2. Basak PY, Vural H, Kazanoglu OO, Erturan I, Buyukbayram HI. Effects of loratadine and cetirizine on serum levels of neuropeptides in patients with chronic urticaria. Int J Dermatol. 2014 Sep 10. 3. Mead RN, Barefoot S, Helms JR, Morgan JB, Kieber RJ.Photodegradation of the antihistamine cetirizine in natural waters. Environ Toxicol Chem. 2014 Oct;33(10):2240-5.

Decision rationale: Cetirizine is an antihistamine that reduces the natural chemical histamine in the body. Histamine can produce symptoms of sneezing, itching, watery eyes, and runny nose. Cetirizine is used to treat cold or allergy symptoms such as sneezing, itching, watery eyes, or runny nose or itching and swelling caused by hives. It is used as an anti-histamine or anti-allergy medication. The injured worker claims to be taking it for pain relief, but it is not an approved medication for this indication and there is no documentation about the worker's stated improved functionality. Therefore the request is not medically necessary.

Pantoprazole Sod Dr 20 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Pantoprazole (Protonix) is in a group of drugs called proton pump inhibitors. It decreases the amount of acid produced in the stomach. It is used to treat erosive esophagitis (damage to the esophagus from stomach acid), and other conditions involving excess stomach acid such as Zollinger-Ellison syndrome. Per Chronic Pain Medical Treatment Guidelines, it is recommended with the use of nonsteroidal anti-inflammatory drugs against both gastrointestinal and cardiovascular risk factors for certain indications. There is no documentation that the worker has a history of ulcer, gastrointestinal bleeding or perforation, uses aspirin, corticosteroids or an anticoagulant, has cardiac disease or is on high dose nonsteroidal anti-inflammatory drugs. She is not older than 65. Therefore the request is not medically necessary.

Ibuprofen 800 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications, NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 22 and 67.

Decision rationale: Per Chronic Pain Medical Treatment Guidelines, anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. (Van Tulder-Cochrane, 2000). A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective nonsteroidal anti-inflammatory drugs in chronic LBP and of antidepressants in chronic low back pain. (Schnitzer, 2004). They are recommended as a second-line treatment after acetaminophen for back pain. In general, there is conflicting evidence that nonsteroidal anti-inflammatory drugs are more effective that acetaminophen for acute low back pain (van Tulder, 2006). This injured worker has had back and hip pain since 2006 and is on multiple medications for pain relief. Ibuprofen is recommended as an option for short-term symptomatic relief for chronic low back pain. Therefore the request is not medically necessary.

Orphenadrine 100 mg, qty 20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: Per Chronic Pain Medical Treatment Guidelines, Orphenadrine is a skeletal muscle relaxant used for the short-term treatment of painful muscle conditions along with rest and physical therapy. It works by helping to decrease pain, which helps muscles to relax. Orphenadrine (Norflex, Banflex, Antiflex, Mio-Rel, Orphenate, generic available) 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. This drug was approved by the food and drug administration in 1959. Chronic Pain Medical

Treatment Guidelines recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in workers with chronic low back pain. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (Van Tulder, 2003) (Van Tulder, 2006) (Schnitzer, 2004) (See, 2008). However, there is no indication this injured worker has been treated with a recommended first line medication for short-term treatment of acute exacerbation of back pain, and since this medication is used for short-term treatment, medical necessity has not been shown in this worker with pain for 8 years. Therefore the request is not certified