

Case Number:	CM14-0179654		
Date Assigned:	11/04/2014	Date of Injury:	07/22/2011
Decision Date:	01/20/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	10/29/2014

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 & Rehabilitation, and is licensed to practice in California. 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 underlying date of injury in this case is 06/22/2011. The date of the utilization review under appeal is 10/22/2014. A procedure note of 06/09/2014 indicates the patient underwent a right L5-S1 epidural injection. On 04/22/2014, the patient was seen in primary treating physician follow-up with low back pain radiating to both legs slightly more on the right than the left with associated numbness and tingling. At that time, the treating physician requested a second epidural injection, noting that the patient previously received 50% relief from a prior epidural injection during which time she increased her home exercises and decreased oral medications. The treating physician requested to repeat this injection. He noted the patient continued to have dermatomal changes at the L5-S1 level including evidence of radiculopathy with a positive straight leg raising sign. He noted that the patient had good relief of at least 50% improvement for 3 weeks following a prior epidural injection. Subsequently the patient clarified that that relief lasted approximately 6-7 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic/physiotherapy x12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58 and 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on manual therapy and manipulation, page 58, states that elective/maintenance care is not recommended. This patient would be expected to have transitioned to an independent active home rehabilitation program by this time frame. A rationale or indication for additional supervised chiropractic/physical therapy is not apparent. This request is not medically necessary.

Pain Management Epidural Injection for Lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

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

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on epidural injections, page 46, states that in the therapeutic phase, repeat blocks should be based on the continued objective documented pain and functional improvement including at least 50% pain relief with associated reduction in medication use for 6-8 weeks. The medical records essentially discuss subjective but not objective improvement in pain and function. It is not clear specifically the degree to which function was improved and the degree to which medication was reduced during the period after her prior epidural injection. Without this information, a repeat injection cannot be supported. This request is not medically necessary.

Back brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: ACOEM Guidelines, Chapter 12 Low Back, page 301, states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The medical records at this time do not provide an alternate rationale to support an indication or benefit from the requested back brace. This request is not medically necessary.

Ketoprofen/Cyclobenzaprine/Lidocaine 10%/3%/5% 129 gm: Upheld

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

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

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on topical analgesics, page 111, states that any compounded product that contains at least one drug that is not recommended is not recommended. The same guideline specifically does not recommend Ketoprofen or Cyclobenzaprine for topical use. The records do not provide an alternate rationale for its use. This request is not medically necessary.

Flurbiprofen/capsaicin/camphor 10/0.025%/2%/1% 120gm: Upheld

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

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

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on topical analgesics, page 111, states that the use of compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The medical records do not contain such detail to support a rationale or indication for this topical product. This request is not medically necessary.

Anaprox-Naproxen 550mg #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiinflammatories Page(s): 22.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on anti-inflammatory medications states that this class of medication is the traditional first line of treatment to reduce pain so that activity and functional restoration can resume. A prior physician review noted that there was no documentation of functional benefit from this medication. The guidelines do not strictly require functional benefit for anti-inflammatory medications. Reports of subjective improvement in pain from this medication without adverse side effects are consistent with the treatment guidelines to continue with such medication. This request is supported by the guidelines. This request is medically necessary.

Protonix-Pantoprazole 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiinflammatories and GI Symptoms Page(s): 66.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on anti-inflammatory medications and gastrointestinal symptoms, page 66, states the clinician should determine if the patient is at risk for gastrointestinal events. The medical records do not provide specific details to provide an indication or rationale as to why this patient is at risk for gastrointestinal events. This request is not medically necessary.

Theramine #90: 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) Treatment in Workers Compensation (TWC); Pain Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers' Compensation, Medical Food

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines does not specifically discuss medical foods. Official Disability Guidelines/Treatment in Workers' Compensation/Pain does discuss medical food, noting that such a product must be labeled for dietary management of a specific medical condition with distinctive nutritional requirements. The medical records do not clearly discuss that this patient has a distinctive nutritional requirement for a particular medical food. This request is not supported by the medical guidelines. This request is not medically necessary.

Sentra #60: 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) Treatment in Workers Compensation (TWC); Pain Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers' Compensation, Medical Food

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines does not specifically discuss medical foods. Official Disability Guidelines/Treatment in Workers' Compensation/Pain does discuss medical food, noting that such a product must be labeled for dietary management of a specific medical condition with distinctive nutritional requirements. The medical records do not clearly discuss that this patient has a distinctive nutritional requirement for a particular medical food. This request is not supported by the medical guidelines. This request is not medically necessary.