

Case Number:	CM14-0209362		
Date Assigned:	12/22/2014	Date of Injury:	03/19/2006
Decision Date:	02/19/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/15/2014

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, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabn

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 34 year old male with date of injury 03/19/06. The treating physician report dated 11/5/14 (52) indicates that the patient presents with pain affecting the mid back, low back and right leg. The patient notes that right leg pain is on the side of the leg, radiating down to the ankle. The physical examination findings reveal weakness of EHL and evetor, tight hamstrings; + right SLR, and a diminished L5 and right S1 to light touch. Prior treatment history includes epidural steroid injections, physical therapy, and prescribed medications of Fexmid, Ultram, Dolgic plus, Orudis, Prilosec, and Norco. MRI findings reveal a 4-5mm protrusion at L4-5 on the left. The current diagnoses are: 1. L/S disc disease with radiculopathy2. Right LE radiculopathy weakness of EHL and evetor3. Mid back pain and bilateral trapezius painThe utilization review report dated 11/20/14 (3) denied the request for Lumbar spinal epidural injection (LESI), Lumbar MRI, Ultracet #60, Lunesta, and Decision for Physical therapy times 4 weeks (no frequency indicated) based on a lack of medical necessity. The requests for Orudis 15 mg #60, and Prilosec 20 mg #30 were certified and deemed medical necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spinal epidural injection (LESI): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation AMA Guides (Radiculopathy)

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

Decision rationale: The patient presents with pain affecting the mid back, low back and right leg with radiation down to the ankle. The current request is for Lumbar spinal epidural injection (LESI). The requesting treating physician report does not address or provide a rationale for a lumbar spinal epidural injection. MTUS Guidelines do recommended ESIs as an option for "treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." Most current guidelines recommend no more than 2 ESI injections. MTUS guidelines go on to state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Reports provided show the patient has had at least 2 prior ESI's, while the treating report dated 11/5/14 (52) states that the patient has had "several." The treating physician report dated 11/5/14 (52) further stated that the patient was diagnosed with lumbar spine radiculopathy. The reports provided show that the patient has received at least two prior epidural steroid injections and the patient's diagnoses of lumbar radiculopathy was not corroborated by an EMG/NCV or MRI test. In this case, there was no documentation of any imaging studies or electrodiagnostic tests in the reports provided, and the patient has had at least 2 prior ESI's. The current request does not satisfy the MTUS guidelines as outlined on page 46. The requested treatment is not medically necessary.

Lumbar MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Magnetic Resonance Imaging

Decision rationale: The patient presents with pain affecting the mid back, low back, and right leg with radiation down to the ankle. The current request is for Lumbar MRI. The treating physician report dated 11/5/14 (52) states, "Previously had MRI at Rolling Oaks - set up my w/c carrier - L4/5 - 4-5mm Protrusion on left - need to have it re-read as pain is on right (this is entirely possible as the disc is pressing the nerves against the bone on the right side causing nerve pain." ODG-TWC guidelines has the following: " Indications for imaging -- Magnetic resonance imaging: -Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit." For an updated or repeat MRI, the patient must be post-operative or present with a new injury, red flags such as infection, tumor, fracture or neurologic progression. In this case, the patient has had a previous MRI and is not presenting with a new injury. The current request does not satisfy the ODG guidelines for an updated or repeat MRI. The requested treatment is not medically necessary.

Orudis 15 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (Pain Chapter)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: The patient presents with pain affecting the mid back, low back, and right leg with radiation down to the ankle. The current request is for Orudis 15 mg #60. The requesting treating physician report does not address or provide a rationale for the current request. Reports provided show the patient has been taking Orudis since at least 6/18/14 (81). Regarding NSAID's, MTUS page 22 supports it for chronic low back pain, at least for short-term relief. MTUS page 60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. In this case, review of the reports do not show documentation of functional benefit or pain reduction from the use of Orudis. Medication efficacy is not discussed in any of the reports provided. There is insufficient documentation and therefore the current request does not satisfy the MTUS guidelines as outlined on page 60. The requested treatment is not medically necessary.

Prilosec 20 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, and cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (Pain Chapter)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-69.

Decision rationale: The patient presents with pain affecting the mid back, low back, and right leg with radiation down to the ankle. The current request is for Prilosec 20 mg #30. The requesting treating physician report does not address or provide a rationale for the current request. Reports provided show the patient has been taking Prilosec since at least 6/18/14 (81). The UR report dated 11/20/14 (8) notes that the patient has a history of gastrointestinal problems. The UR report then goes on to certify the request for Prilosec. The MTUS guidelines state Omeprazole is recommended with precautions, "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." Clinician should weigh indications for NSAIDs against GI and cardiovascular risk factors, determining if the patient is at risk for gastrointestinal events. In this case, there was documentation provided of current NSAID but the treating physician has not documented any GI issues relating to NSAID usage. The requested treatment is not medically necessary.

Ultracet #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82. Decision based on Non-MTUS Citation Official Disability Guidelines (Pain Chapter)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The patient presents with pain affecting the mid back, low back, and right leg with radiation down to the ankle. The current request is for Ultracet #60. The patient had previously been taking Ultram since at least 6/18/14 (81) prior to the physician prescribing Ultracet. Reports provided show the patient was first prescribed Ultracet on 11/5/14. MTUS guidelines state the following regarding Initiating Opioid therapy, "(a) intermittent pain: Start with a short-acting opioid trying one medication at a time. (b) Continuous pain: extended release opioids are recommended. Patients on this modality may require a dose of "rescue" opioids. The need for extra opioid can be a guide to determine the sustained release dose required. (c) Only change 1 drug at a time. (e) If partial analgesia is not obtained, opioids should be discontinued." In this case, the patient is no longer taking Ultram and a trial of Ultracet is now being initiated. The patient is currently working with no limitations or restrictions. The current request satisfies the MTUS guidelines for initiating opioid therapy as outlined on page(s) 76-78. The requested treatment is medically necessary.

Lunesta: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (Pain Chapter)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Mental Illness & Stress

Decision rationale: The patient presents with pain affecting the mid back, low back, and right leg with radiation down to the ankle. The current request is for Lunesta. The treating physician report dated 11/05/14 (52) notes that the prescription was for Lunesta #3 but the UR report dated 11/20/14 does specify a quantity. The ODG guidelines support the usage for Lunesta for short-term usage only 2-3 weeks. In this case, there is no quantity of Lunesta specified, so therefore the current request does not satisfy the ODG guidelines. The requested treatment is not medically necessary.

Physical therapy times 4 weeks (no frequency indicated): 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 Physical medicine Page(s): 98-99.

Decision rationale: The patient presents with pain affecting the mid back, low back, and right leg with radiation down to the ankle. The current request is for Physical therapy times 4 weeks (no frequency indicated). The patient has received prior physical therapy but the reports provided do not specify an amount of visits that have been received. MTUS supports physical medicine (physical therapy and occupational therapy) 8-10 sessions for myalgia and neuritis type conditions. The MTUS guidelines only provide a total of 8-10 sessions over 4 weeks and the patient is expected to then continue on with a home exercise program. In this case, the current request does not specify a frequency the PT visits will take place over the 4 weeks. Furthermore, it is not clear how many prior physical therapy visits the patient has received and therefore it is uncertain if the request for additional visits exceeds the recommendation of 8-10. The current request does not satisfy the MTUS guidelines as outlined on page(s) 98-99. The requested treatment is not medically necessary.