

Case Number:	CM15-0006610		
Date Assigned:	01/16/2015	Date of Injury:	05/05/1999
Decision Date:	03/19/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	01/11/2015

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 53-year-old male who reported an injury on 05/05/1999. The mechanism of injury was not provided. His diagnoses include lumbar disc disease with myelopathy. Past treatment was noted to include surgery, bracing, and medications. An x-ray was performed of the lumbar spine which showed bone graft at the L4-5 and L5-S1 disc space, as well as posterior spinal instrumentation from L4 to S1. On 12/09/2009, it was indicated the injured worker had complaints of pain to his low back that radiated to his bilateral lower extremities. He reported painless tingling and numbness to his bilateral legs and feet. Upon physical examination, it was indicated the injured worker had a positive straight leg raise bilaterally and decreased deep tendon reflexes, as well as decreased sensation. Medications were not included in the report. The treatment plan was noted to include Norco, Neurontin, Flexeril, Keflex, and OxyContin, as well as a spinal cord stimulator. A request was received for four trigger point injections without a rationale.

IMR ISSUES, DECISIONS AND RATIONALES

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

Four trigger point Injections: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 112.

Decision rationale: According to the California MTUS Guidelines, trigger point injections are recommended for myofascial pain syndrome. The criteria for trigger point injections are documentation of circumscribed trigger points with evidence of a twitch upon palpation; symptoms lasting for more than 3 months; unresponsiveness to previous conservative management; and radiculopathy not present. There is no recent documentation submitted for review indicating the injured worker's current functional status. Consequently, the request is not supported by the evidence based guidelines. Additionally, the request does not specify at which level these are to be given. As such, the request for four trigger point injections is not medically necessary.

Flexeril 10mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

Decision rationale: According to the California MTUS Guidelines, Flexeril is a muscle relaxant that is not to exceed the use of 3 weeks. There were no recent clinical documentation indicating the efficacy or duration of use of this medication. Consequently, the request is not supported by the evidence based guidelines. Additionally, the request does not specify duration or frequency of use. As such, the request for one prescription for Flexeril 10mg, #60 is not medically necessary.

Topamax 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 21.

Decision rationale: According to the California MTUS Guidelines, Topamax is an antiepileptic medication that has been shown to have variable efficacy with failure to demonstrate efficacy in neuropathic pain. There were no recent notes for review indicating the rationale or efficacy of this medication. Consequently, the request is not supported by the evidence based guidelines. Additionally, the request does not specify duration and frequency of use. As such, the request for Topamax 50mg #60 is not medically necessary.

One bilateral fluoroscopic guided diagnostic transforaminal epidural steroid injection S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: According to the California MTUS Guidelines, epidural steroid injections are to reduce pain and inflammation, thereby facilitating progress in an active therapeutic exercise program. The guidelines indicate the criteria for ESIs are radiculopathy on examination and corroborated with imaging studies and unresponsiveness to conservative treatment to include exercises, physical methods, NSAIDs, and muscle relaxants. The clinical documentation submitted for review did not provide recent subjective and objective findings regarding radiculopathy or the adjunctive participation in active therapeutic exercise program. Consequently, the request is not supported by the evidence based guidelines. As such, the request for one bilateral fluoroscopic guided diagnostic transforaminal epidural steroid injection S1 is not medically necessary.

Remeron 50mg #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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13.

Decision rationale: According to the California MTUS Guidelines, antidepressants, such as Remeron, are recommended for neuropathic and nonneuropathic pain. Assessment of treatment efficacy should include pain outcomes, evaluation of function, changes in use of other analgesic medication, sleep quality and duration, psychological assessment, and side effects. There is no recent clinical documentation indicating efficacy or rationale for the need of this medication. Consequently, the request is not supported by the evidence based guidelines. Additionally, the request does not specify duration and frequency of use. As such, the request for one prescription of Remeron 50mg #60 is not medically necessary.

One prescription for Doral 15mg #30: 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 Benzodiazepines Page(s): 24.

Decision rationale: According to the California MTUS Guidelines, benzodiazepines are not recommended for more than 4 weeks. There was no recent clinical documentation indicating a rationale, efficacy, or duration of use of this medication. Consequently, the request is not supported by the evidence based guidelines. Additionally, the request does not specify duration and frequency of use. As such, the request for one prescription for Doral 15mg #30 is not medically necessary.