

Case Number:	CM15-0103143		
Date Assigned:	06/05/2015	Date of Injury:	04/16/2009
Decision Date:	07/09/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	05/28/2015

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: New York

Certification(s)/Specialty: Anesthesiology

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 62 year old female, who sustained an industrial injury on 4/16/2009. Diagnoses include chronic low back pain, degenerative disc and herniated disc L4-5 and L5-S1 and lumbar radiculopathy. Treatment to date has included medications including Mobic, Gabapentin, Prilosec, Robaxin and Lidocaine. Per the Primary Treating Physician's Progress Report dated 5/13/2015, the injured worker reported pain in the neck, lower back and bilateral knees. Pain is rated as 5-6/10 with medication and 8-9/10 without medication. Physical examination of the lumbosacral spine revealed tenderness with painful, limited ranges of motion. Straight leg raise is positive sitting and supine at 70 degrees on the right and 45 degrees on the left. The plan of care included medications, diagnostics and physiotherapy. Authorization was requested for physical therapy for the lumbar spine, computed tomography (CT) scan of the lumbar spine, Methocarbamol, Omeprazole, Neurontin, Lidocaine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the lumbar spine quantity 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy: Low Back Pain.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, the patient has completed prior physical therapy sessions and there is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the requested additional PT sessions. Medical necessity for the requested service has not been established. The requested services are not medically necessary.

CT scan of the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: According to ACOEM, magnetic resonance imaging (MRI) has largely replaced computed tomography (CT) scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multi-planar capability. In this case, the patient has ongoing low back pain with clinical deficits on exam but there is no documentation of prior studies obtained for this 6 year old injury, and no specific indication from the provider on the indication for requesting a CT study. Medical necessity for the requested CT scan of the lumbar spine has not been established. The requested CT scan is not medically necessary.

Methocarbamol 750mg quantity 30 with two refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 98.

Decision rationale: Robaxin (Methocarbamol) is an antispasmodic muscle relaxant. The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. According to CA MTUS Guidelines, muscle relaxants are not recommended for the long-term treatment of chronic pain. They are not recommended to be used for longer than 2-3 weeks. There is no documentation of functional improvement from any previous use of this medication. According to the guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Omeprazole 20mg quantity 60 with two refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation indicating the patient has any GI symptoms or GI risk factors. This patient is not currently taking an NSAID. Based on the available information provided for review, the medical necessity for Omeprazole has not been established. The requested medication is not medically necessary.

Neurontin 300mg quantity 60 with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The records do not document that the patient has neuropathic pain related to her chronic low back condition. In addition, there was no documentation of functional improvement from use of this medication. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

Lidocaine Hydrochloride 3% with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. In this case, there is no documentation of intolerance to other previous oral medications. Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) is FDA approved for neuropathic pain, and used off-label for diabetic neuropathy. No other Lidocaine topical creams or lotions are indicated for neuropathic or non-neuropathic pain. Medical necessity for the topical analgesic cream has not been established. The requested medication is not medically necessary.