

Case Number:	CM15-0010606		
Date Assigned:	01/28/2015	Date of Injury:	04/03/2012
Decision Date:	04/01/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/20/2015

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: Emergency 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 (IW) is a 42-year-old male who sustained an industrial injury on 4/30/2012. The IW has complaints of low back and right leg pain with numbness and tingling. He uses neurontin at bedtime, hydrocodone once or twice a day and Flexeril once or twice a day to help him manage his pain and enable him to walk outside and do a little bit more activity. The diagnoses have included chronic low back pain/sprain with facet syndrome and right lower extremity radiculitis. Evaluation has included electrodiagnostic testing 1/6/14 of the right lower extremity which was normal, magnetic resonance imaging (MRI) of the lumbar on 5/25/12 showed no evidence of disc bulge or herniation, multilevel mild ligamentum flavum and hypertrophic facet changes; lumbar spine MRI on 8/5/13 showed no interval change to previous MRI, lumbar spine X-rays showed facet degenerative change at L4-5 and L5-S1 with no instability on flexion and extension views. The IW Treatment has included a Transcutaneous Electrical Nerve Stimulation (TENS) unit, medications, and Thermacare pads. Work status noted to be modified with limitations to lifting, bending, and prolonged standing. According to the utilization review performed on 12/30/14, the requested right L4-L5 and L5-S1 facet injection, Neurontin 800mg BID PRN, Flexeril 5mg BID PRN, Hydrocodone 5/325mg BID PRN, Thermacare Pads QD PRN, MRI LS and X-rays has been non-certified. CA MTUS/ACOEM guidelines were used.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L4 - L5 and L5 - S1 facet injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th Edition (web), 2014, Low Back, Facet Injections, SI joint injections.

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

Decision rationale: CA MTUS recommends the use of epidural steroid injections as an option for radicular pain. Criteria requires that "radiculopathy must be documented by physical examination and corroborated by imaging studies and / or electrodiagnostic testing." The reviewed chart includes a statement from the IW provider that there is L5 radicular symptoms. However, there are no electrodiagnostic studies included or discuss and the radiographic imaging included does not support radiculopathy. The quest does not meet MTUS guidelines. The request for L4 - L5 and L5 - S1 facet injections are not medically necessary.

Neurontin 800mg BID PRN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Anti-Epilepsy Drug) Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin, Anti-epilepsy drugs Page(s): 49, 16-21.

Decision rationale: According to CA MTUS, gabapentin is an anti-epilepsy drug, which has efficacy for diabetic neuropathy or post-herpetic neuropathy. It has also been considered a first line agent for neuropathic pain. There is not sufficient evidence to recommend the use of these medication for the treatment of chronic non-specific, non-neuropathic axial low back pain. Ongoing use of these medications recommends "documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects." The IW does not have diabetic neuropathy or post-herpetic conditions. The documentation reports improvement of pain with the use of medications, but specific responses to individual medications is not noted in the record. Additionally, the request does not include dosing frequency. Without this documentation, the request for gabapentin is not medically necessary in accordance with MTUS guidelines.

Flexeril 5mg BID PRN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: According to CA MTUS, cyclobenzaprine is recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. The IW has been receiving this prescription for a minimum of 12 months according to submitted records. This greatly exceeds the recommended time frame of treatment. In addition, the request does not include dosing frequency or duration. The IW's response to this medication is not discussed in the documentation. The request is not medically necessary.

Hydrocodone 5/325mg BID PRN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-81, 86.

Decision rationale: CA MTUS, chronic pain guidelines, offer very specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. These recommendations state that the lowest possible dose be used as well as "ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects." It also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. The included documentation fails to include the above recommended documentation. In addition, the request does not include dosing frequency or duration. There is not toxicology report included in the record. The request for Hydrocodone analgesia is not medically necessary.

Thermacare Pads QD PRN: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th Edition (web), 2014, Low back, heat therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back: heat therapy.

Decision rationale: CA MTUS is silent on this topic. According to ODG guidelines referenced above, heat therapy is recommended as an option stating "studies show continuous low-level heat wrap therapy to be effective for treating low back pain." Further guidelines indicate Thermacare heatwrap to be more effective than other competing manufacturers. The IW has been using Thermacare pads for a minimum of 6 months. The records do not relate specific efficacy to the use of this product. Nonetheless, this product has been demonstrated to provide

relief and is supported by guidelines. The request for Thermacare pads is medically necessary and appropriate.

MRI LS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back pain - magnetic resonance imaging.

Decision rationale: CA MTUS ACOEM guidelines recommend imaging studies for cases "in which surgery is considered or red-flag diagnoses are being evaluated." ODG guidelines state "repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology." Documentation does not support significant changes in subjective complaints of objective findings. There is not documentation of new injuries or adjustments to analgesic medication. The IW previous had a lumbar MRI. The IW was evaluated by neurosurgery and determined to not be a surgical candidate. The request for a lumbar MRI is not medically necessary.

X-Rays: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: According to CA MTUS, "lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks." The IW has had ongoing low back for several years and has previously had advanced diagnostic imaging including and MRI. There is no documentation to support a new injure of concern for new pathology. Documentation does not support the IW has any of the referenced red flags. The request for radiographic imaging is not medically necessary.