

Case Number:	CM15-0135120		
Date Assigned:	07/23/2015	Date of Injury:	03/18/2008
Decision Date:	08/24/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	07/13/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 is a 57-year-old male who sustained an industrial injury on 03/18/2008. Mechanism of injury was not found with documentation but he had multiple body parts injuries. Diagnoses include multilevel lumbar disc disorder with associated foraminal stenosis and central canal stenosis most notable at L5-S1, chronic low back pain, with neurological deficits of bilateral lower extremity motor and sensory neuropathy, and bilateral nerve roots L4, L5, and S1 poly radiculopathy with weakness, reduced sensation and right calf atrophy and sciatica. Treatment to date has included diagnostic studies, medications, use of a Transcutaneous Electrical Nerve Stimulation unit, trigger point injections, and radio frequency rhizotomy procedure. A physician progress note dated 06/03/2015 documents the injured worker complains of chronic low back pain, muscle spasms with limited range of motion and diaphoresis. He has muscle spasm with limited range of motion, sleep impairment induced by chronic pain, depression induced by chronic pain and lack of sleep, diarrhea mildly aggravated by non-steroidal anti-inflammatory medications, Oligodendroglioma, Grade I with carbamazepine controlled seizures-non-industrial. He is sleeping 7 hours a night with 2 interruptions due to pain and 25 minute to induction. He is still walking daily and performing water exercises in his hot tub daily to tolerance. Activities of daily living are limited by chronic pain, but are still tolerated with his current medications. His gait exhibited asymmetrical weight bearing and antalgia. Cadence remained slow with reduced progression of weight bearing from heel-strike though foot-flat to toe push off. Lumbar spine range of motion is restricted. There is tenderness on palpation to the thoraco-lumbar junction and lumbar sacral junction. Treatment requested

requested is for 12 sessions of cognitive behavioral training, 4 sessions of psychotherapy psychological trial testing, Zorvolex 35mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zorvolex 35mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drug.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAI Page(s): 22, 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, NSAI.

Decision rationale: Pursuant to the to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Zorvolex 35mg #60 is not medically necessary. Nonsteroidal anti-inflammatory drugs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. There appears to be no difference between traditional nonsteroidal anti-inflammatory drugs and COX-2 nonsteroidal anti-inflammatory drugs in terms of pain relief. The main concern of selection is based on adverse effects. Diclofenac is not recommended as a first-line drug due to its increased risk profile. In this case, the injured worker's working diagnoses are multilevel lumbar disc disorder associated foraminal stenosis and central canal stenosis most notable at L5 - S1; and chronic low back pain; muscle spasm and decreased range of motion; sleep impairment secondary to chronic pain; depression; and low back pain flare from performing independent exercises on a stabilization ball to treat chronic pain. Subjectively, the interval history states TENS has alleviated the pain over 50% and is worn daily. Celebrex 200 mg was denied and the treating provider is now requesting Zorvolex. Lyrica has reduced neuralgia over 50%. Objectively, the gait is asymmetrical and antalgic. There are trigger points over the paravertebral muscles. Motor examination is grossly normal in the lower extremities. There is no documentation in the medical record of first line nonspecific nonsteroidal anti-inflammatory drugs. Diclofenac is not recommended as a first-line drug due to its increased risk profile. Consequently, absent clinical documentation of first line treatment failure with first-line nonsteroidal anti-inflammatory drugs, Zorvolex 35mg #60 is not medically necessary.

4 sessions of psychotherapy psychological trial testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7-Independent Medical Examinations and Consultations, Official Disability Guidelines, Pain.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Pursuant to the ACOEM, four session's psychotherapy, psychological trial testing is not medically necessary. An occupational health practitioner may refer to other

specialists if the diagnosis is certain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultation is designed to aid in the diagnosis, prognosis and therapeutic management of a patient. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opiates; antibiotics require close monitoring. In this case, the injured worker's working diagnoses are multilevel lumbar disc disorder associated foraminal stenosis and central canal stenosis most notable at L5 - S1; and chronic low back pain; muscle spasm and decreased range of motion; sleep impairment secondary to chronic pain; depression; and low back pain flare from performing independent exercises on a stabilization ball to treat chronic pain. Subjectively, the interval history states TENS has alleviated the pain over 50% and is worn daily. Celebrex 200 mg was denied and the treating provider is now requesting Zorvolex. Lyrica has reduced neuralgia over 50%. Objectively, the gait is asymmetrical and antalgic. There are trigger points over the paravertebral muscles. Motor examination is grossly normal in the lower extremities. The treating provider form a fear avoidance beliefs questionnaire and interpreted psychological testing. The treating provider requested four sessions of psychotherapy and psychological trial testing. There is no clinical indication for psychological trial testing until a psychological evaluation by the appropriate provider takes place. The request/order for four sessions of psychotherapy is premature until the injured worker is evaluated. Consequently, absent clinical documentation with a clinical evaluation by the psychologist with an opinion indicating four sessions of psychotherapy are clinically indicated, four sessions psychotherapy, psychological trial testing is not medically necessary.

12 sessions of cognitive behavioral training: 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 Cognitive behavioral therapy (CBT) Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Cognitive behavioral therapy (CBT).

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, 12 sessions of cognitive behavioral training are not medically necessary. Cognitive behavioral therapy guidelines for chronic pain include screening for patients with risk factors for delayed recovery including fear avoidance beliefs. Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after four weeks if lack of progress from physical medicine alone. Initial trial of 3 to 4 psychotherapy visits over two weeks. With evidence of objective improvement, up to 6 ? 10 visits over 5 - 6 weeks (individual sessions). In this case, the injured worker's working diagnoses are multilevel lumbar disc disorder associated foraminal stenosis and central canal stenosis most notable at L5 - S1; and chronic low back pain; muscle spasm and decreased range of motion; sleep impairment secondary to chronic pain; depression; and low back pain flare from performing independent exercises on a stabilization ball to treat chronic pain. Subjectively, the interval history states

TENS has alleviated the pain over 50% and is worn daily. Celebrex 200 mg was denied and the treating provider is now requesting Zorvolex. Lyrica has reduced neuralgia over 50%. Objectively, the gait is asymmetrical and antalgic. There are trigger points over the paravertebral muscles. Motor examination is grossly normal in the lower extremities. The treating provider form a fear avoidance beliefs questionnaire and interpreted psychological testing. The guidelines recommend an initial trial of 3-4 psychotherapy visits over two weeks. With evidence of objective functional improvement, an additional 6 - 10 visits may be clinically indicated. Consequently, absent guideline recommendations with a request for 12 sessions of cognitive behavioral therapy (guidelines recommend 3-4), 12 sessions of cognitive behavioral training are not medically necessary.