

Case Number:	CM15-0136819		
Date Assigned:	07/30/2015	Date of Injury:	11/29/2014
Decision Date:	09/24/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/14/2015

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 is a 38 year old female, who sustained an industrial injury on 11-29-2014. She has reported subsequent low back and bilateral leg pain and was diagnosed with lumbago, lumbar sprain and strain and right leg radiculopathy. MRI dated 11-30-2014 showed broad based disc protrusions at L4-L5 and L5-S1 with mild to moderate central canal narrowing at L4-L5, moderate disc height loss and degenerative endplate changes at L4-L5 and ligamentum flavum thickening and mild facet arthropathy from L3-L4 and L5-S1. Treatment to date has included medication and physical therapy. In a doctor's first report of illness or injury dated 06-11-2015, the injured worker reported intermittent low back pain with left radiating and right numbness and bilateral leg pain that was rated as 5 out of 10 after slipping and falling at work. Objective findings were notable for pain and tenderness in the mid to distal lumbar segments, radiculopathy in the left lower extremity in the L5 and S1 dermatomes, guarded and restricted range of motion of the lumbar spine and tingling and numbness in the lateral thigh, anterior lateral and posterior leg and foot, consistent with an L5-S1 dermatomal pattern. This report notes that the patient may require work restrictions of no heavy lifting, bending or prolonged periods of sitting or standing. A request for authorization of Nabumetone (Relafen) 750 mg #120, Lansoprazole (Prevacid) Delayed Release capsule 30 mg #120, Ondansetron 8 mg ODT #30, Cyclobenzaprine Hydrochloride 7.5 mg #120, Tramadol ER 150 mg #90, Eszopiclone tabs 1 mg #30, MRI of the lumbar spine and consult with MD for possible LESI was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nabumetone (Relafen) 750mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

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

Decision rationale: As per CA MTUS guidelines, non-steroidal anti-inflammatory drugs (NSAID's) are recommended as a second line treatment after Acetaminophen for treatment of acute exacerbations of chronic back pain and are recommended as an option for short-term symptomatic relief of chronic low back pain. NSAID's were found to be no more effective than other drugs such as Acetaminophen, narcotic analgesics and muscle relaxants and had more adverse effects than Acetaminophen. Nabumetone can be used for treatment of osteoarthritis with a recommended starting dose of 1000 mg per day. Use for moderate pain is off-label. The doctor's first report of illness or injury dated 06-11-2015 noted the presence of 5 out of 10 low back and left lower extremity pain. The request for authorization shows that the physician was requesting 750 mg of Nabumetone three times a day for inflammatory pain. There was no indication that Acetaminophen had been tried for relief of pain nor were there any conditions documented which would have contraindicated the use of Acetaminophen. In addition, the requested dosage far exceeds MTUS recommendations for a starting dose of 1000 mg per day. There were no extenuating circumstances documented to support the use of this medication. Therefore, the request is not medically necessary.

Lansoprazole (Prevacid) Delayed Release caps 30mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID, GI Symptoms & cardiovascular risk Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: According to CA MTUS, a proton pump inhibitor, such as Prevacid (Lansoprazole), is recommended for patients taking non-steroidal anti-inflammatory drugs (NSAIDs) with documented gastrointestinal (GI) distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any GI symptoms or 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 of any reported GI complaints. It appears that the only reason for prescribing this medication may have been due to the fact that one NSAID medication was requested. This medication was found to be not medically necessary. Based on the available information provided for review, the medical necessity for Prevacid has not been established. The requested medication is not medically necessary.

Ondansetron 8mg ODT #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Antiemetics.

Decision rationale: MTUS guidelines are silent regarding the use of Ondansetron so alternative guidelines were referenced. As per ODG, Ondansetron is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment and postoperative use as well as for acute gastroenteritis. There is no documentation as to why this medication was prescribed nor was there any indication that it was prescribed for the FDA covered indications above. The documentation is insufficient to establish medical necessity. Therefore, the request for authorization of Ondansetron is not medically necessary.

Cyclobenzaprine Hydrochloride 7.5mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: As per CA MTUS guidelines, muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In most cases of low back pain, these medications show no additional benefit beyond non-steroidal anti-inflammatory drugs (NSAID's) in pain and overall improvement. Cyclobenzaprine is only recommended for a short course of therapy and is only noted to have a modest effect for treatment of back pain at the price of adverse effects. There is no evidence of a failure of other analgesic agents prior to the decision to proceed with prescription of Cyclobenzaprine. There was no documentation of muscle spasm and no extenuating circumstances to support the use of this medication over other pain medications with a lower side effect profile. Therefore, the request for Cyclobenzaprine is not medically necessary.

Tramadol ER 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 94.

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

Decision rationale: The medication requested for this patient is Tramadol. According to CA MTUS guidelines, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. This medication is not recommended as a first-line oral analgesic. Before initiating opioid therapy there must be baseline pain and functional assessments using a validated instrument or numerical rating scale, a psychosocial assessment should be performed, there must be a failure of non-opioid analgesics and goals should be set. Although the severity of pain was rated and a psychosocial assessment was performed, the documentation submitted did not indicate that the injured worker had failed treatment with other non-opioid analgesic agents and there was no description of goals documented. In addition, there was no discussion of the presence of risk factors for opioid misuse or dependence documented. Therefore, the request for authorization of Tramadol is not medically necessary.

Eszopiclone tabs 1mg #30: Upheld

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

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

Decision rationale: MTUS is silent regarding the use of Eszopiclone so alternative guidelines were referenced. As per ODG, Eszopiclone is not recommended for long term use but can be recommended for short term use. The hazard of death ratio is 30.62 compared to Zolpidem at 4.82. The documentation submitted shows that the injured worker was reporting difficulty sleeping and fatigue, however there was no other documentation as to the injured worker's sleep hygiene or discussion regarding the exact nature of the sleep difficulties, i.e., trouble falling asleep, staying asleep, etc. nor was there a discussion of the duration of sleep per night or the injured worker's sleep cycles. Given the higher than risk profile for Eszopiclone as noted by ODG with a hazard for death ratio of 30.62, and the lack of documentation as to the exact nature of the sleep difficulties as noted above, the documentation submitted is insufficient to establish that this medication is medically necessary. Therefore, the request is not medically necessary.

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Work Loss Data Institute, Section : Low Back & Lumbar & Thoracic (Acute & Chronic) (updated 5/15/15).

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

Decision rationale: As per ACOEM guidelines, objective findings that identify specific nerve compromise on neurological examination are sufficient to warrant lumbar imaging in those who

don't respond to treatment and for whom surgery is an option but when the neurologic examination is less clear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. An MRI is warranted when cauda equina, tumor, infection or fracture is strongly suspected and plain radiographs are negative. There was no documentation of concern from the physician for these conditions. Although there was evidence of pain and tingling and numbness in the L5-S1 dermatomal pattern, an MRI of the lumbar spine had been performed on 11-30-2014, which already showed findings of broad based disc protrusions, ligamentum flavum thickening and mild facet arthropathy of L5-S1. In addition, there was no indication that the injured worker was a candidate for spinal surgery. Therefore, the request for MRI of the lumbar spine is not medically necessary.

Consult with MD for poss LESI: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, Independent Medical Examinations and Consultation, page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Office Visits.

Decision rationale: As per CA MTUS, epidural steroid injections are recommended as an option for treating radicular pain. As per ACOEM, epidural steroid injections may lead to short-term improvement of leg pain and sensory deficits in individuals with nerve root compression as a result of a herniated disk but does not offer any long term functional benefit. As per ODG, the need for a clinical office visit with a physician is individualized based on a review of patient concerns, signs and symptoms, clinical stability and physician judgment. The documentation submitted shows that the injured worker reported intermittent low back pain with left radiating and right numbness and bilateral leg pain that was rated as 5 out of 10 along with pain, tenderness and guarding of the lumbar spine with radicular symptoms in the left lower extremity. The physician noted that the injured worker had been seen by a pain management specialist (Dr. Ho.) who had recommended possible lumbar epidural block. The physician noted that he believed either a lumbar facet injection or lumbar epidural block was appropriate and that referral was being made to Dr. Ho for consideration of the above recommendation. Given the injured worker's signs and symptoms, the documentation submitted supports the medical necessity of this request. Therefore, the request for consultation for possible epidural steroid injection is medically necessary.