

Case Number:	CM15-0143086		
Date Assigned:	08/03/2015	Date of Injury:	03/12/2010
Decision Date:	09/23/2015	UR Denial Date:	07/10/2015
Priority:	Standard	Application Received:	07/23/2015

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

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 55 year old male who sustained an industrial injury on 3-12-2010. He injured his fist by hitting a garage door and overdosed on medication due to frustration. He has reported low back pain and has been diagnosed with lumbar spine herniated nucleus pulposus with radiculopathy, posterior annular fissures at L2-3, L4-5, 4.7 mm L2-3 disc herniation with encroachment on the exiting nerve roots, acute L3-4 radiculopathy on the left, and sleep apnea. Treatment has included injections, medications, medical imaging, chiropractic care, and conservative methods. There was spasm noted to the thoracolumbar spine. Range of motion was decreased. Straight leg raise was positive on the right at 45 degrees and 75 degrees to the left. The treatment plan included follow up. The treatment request included Anaprox, Prilosec, and urine drug test, quantitative testing of urine, 4 trigger point injections, and 1 follow up appointment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro (DOS 3/3/15, 4/2/15): Anaprox DS 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, (Chronic), NSAIDS, hypertension and renal function (2015).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The request for authorization is dated 04/02/15. MRI of the lumbar spine, 05/10/12, shows 4-mm disc protrusion at L2-3 with resulting abutment of the descending L3 nerve roots bilaterally and right and left L2 nerve roots; at L4-5 there is a 3-mm disc protrusion. EMG/NCV, 08/18/10, shows a mild acute L3 and L4 radiculopathy on the left. Physical examination of the posterior lumbar musculature reveals tenderness to palpation bilaterally with increased muscle rigidity. There are numerous trigger points that are palpable and tender throughout the lumbar paraspinal muscles. Decreased range of motion with obvious muscle guarding. Sensory exam with Wartenberg pinprick wheel is decreased along the posterior lateral thigh and posterior lateral calf in approximately the L5-S1 distribution. Straight leg raise is positive at about 60 degrees, which caused radicular symptoms to lower extremities. He has had extensive conservative management including undergoing lumbar epidural steroid injections with his last one performed on 04/09/12, which provided 60% pain relief, lasting a good 3-1/2 months. He feels that the combination of Anaprox, Topamax and Zanaflex enables him to keep his pain manageable as well as enable him to keep his Norco down to a minimum. He has also been experiencing less GI discomfort while on Prilosec, which he takes twice a day. He is able to perform simple chores around the house including cooking, cleaning and doing laundry. He has also been able to actively participate in the home exercise program with less discomfort. Patient's medications include Norco, Topamax, Neurontin, Naproxen, Prilosec and Xanax. Per AME report dated 05/12/15, the patient is not working. MTUS Chronic Pain Medical Treatment Guidelines, page 22 for Anti-inflammatory medications states: Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective non-steroidal anti-inflammatory drugs (NSAIDs) in chronic LBP and of antidepressants in chronic LBP. Per progress report dated 03/03/15 and 04/02/15, provider's reason for the request is it "enable him to keep his pain manageable." Patient has been prescribed Anaprox since at least 04/09/14. MTUS supports the use of anti-inflammatory as traditional first line of treatment for pain. However, other than a general statement of "enables him to keep his pain manageable," the provider does not specifically discuss efficacy of Anaprox for the patient. MTUS Guidelines page 60 states that when medications are used for chronic pain, recording of pain and function needs to be provided. Given the lack of documentation, the request does not meet guidelines indication. Therefore, the request is not medically necessary.

Retro (DOS 3/3/15, 4/2/15): Prilosec 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms and cardiovascular risk. Decision based on Non-MTUS Citation

Official Deniability Guidelines (ODG), Pain (Chronic): NSAIDS, GI Symptoms & cardiovascular risk, Proton Pump Inhibitor (PPIs).

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

Decision rationale: The patient presents with low back pain with radicular symptoms to both lower extremities, but right greater than left. The request is for Retro (DOS 3/3/15, 4/2/15): Prilosec 20mg #60. The request for authorization is dated 04/02/15. MRI of the lumbar spine, 05/10/12, shows 4-mm disc protrusion at L2-3 with resulting abutment of the descending L3 nerve roots bilaterally and right and left L2 nerve roots; at L4-5 there is a 3-mm disc protrusion. EMG/NCV, 08/18/10, shows a mild acute L3 and L4 radiculopathy on the left. Physical examination of the posterior lumbar musculature reveals tenderness to palpation bilaterally with increased muscle rigidity. There are numerous trigger points that are palpable and tender throughout the lumbar paraspinal muscles. Decreased range of motion with obvious muscle guarding. Sensory exam with Wartenberg pinprick wheel is decreased along the posterior lateral thigh and posterior lateral calf in approximately the L5-S1 distribution. Straight leg raise is positive at about 60 degrees, which caused radicular symptoms to lower extremities. He has had extensive conservative management including undergoing lumbar epidural steroid injections with his last one performed on 04/09/12, which provided 60% pain relief, lasting a good 3-1/2 months. He feels that the combination of Anaprox, Topamax and Zanaflex enables him to keep his pain manageable as well as enable him to keep his Norco down to a minimum. He has also been experiencing less GI discomfort while on Prilosec, which he takes twice a day. He is able to perform simple chores around the house including cooking, cleaning and doing laundry. He has also been able to actively participate in the home exercise program with less discomfort. Patient's medications include Norco, Topamax, Neurontin, Naproxen, Prilosec and Xanax. Per AME report dated 05/12/15, the patient is not working. MTUS page 69, NSAIDs, GI symptoms & cardiovascular risk Section states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Per progress report dated 03/03/15 and 04/02/15, provider's reason for the request is "He has also been experiencing less GI discomfort." Patient has been prescribed Prilosec since at least 04/09/14. In this case, provider has not documented GI assessment to warrant a prophylactic use of a PPI. And provider has not indicated what gastric complaints there are, and why he needs to continue. Additionally, the patient is prescribed Anaprox, an NSAID, however, the request for Anaprox has not been authorized. Therefore, the request is not medically necessary.

Retro (DOS 3/3/15, 4/2/15): 4 Trigger Point Injections QTY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for trigger point injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines trigger point injections Page(s): 122.

Decision rationale: The patient presents with low back pain with radicular symptoms to both lower extremities, but right greater than left. The request is for Retro (DOS 3/3/15, 4/2/15): 4 Trigger Point Injections QTY. The request for authorization is dated 04/02/15. MRI of the lumbar spine, 05/10/12, shows 4-mm disc protrusion at L2-3 with resulting abutment of the descending L3 nerve roots bilaterally and right and left L2 nerve roots; at L4-5 there is a 3-mm disc protrusion. EMG/NCV, 08/18/10, shows a mild acute L3 and L4 radiculopathy on the left. Physical examination of the posterior lumbar musculature reveals tenderness to palpation bilaterally with increased muscle rigidity. There are numerous trigger points that are palpable and tender throughout the lumbar paraspinal muscles. Decreased range of motion with obvious muscle guarding. Sensory exam with Wartenberg pinprick wheel is decreased along the posterior lateral thigh and posterior lateral calf in approximately the L5-S1 distribution. Straight leg raise is positive at about 60 degrees, which caused radicular symptoms to lower extremities. He has had extensive conservative management including undergoing lumbar epidural steroid injections with his last one performed on 04/09/12, which provided 60% pain relief, lasting a good 3-1/2 months. He feels that the combination of Anaprox, Topamax and Zanaflex enables him to keep his pain manageable as well as enable him to keep his Norco down to a minimum. He has also been experiencing less GI discomfort while on Prilosec, which he takes twice a day. He is able to perform simple chores around the house including cooking, cleaning and doing laundry. He has also been able to actively participate in the home exercise program with less discomfort. Patient's medications include Norco, Topamax, Neurontin, Naproxen, Prilosec and Xanax. Per AME report dated 05/12/15, the patient is not working. The MTUS Guidelines, on page 122, state that trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. Per progress report dated 03/03/15 and 04/02/15, provider's reason for the request is "These injections are occasionally necessary to maintain function and help decrease medication use." In this case, it appears the provider is requesting a repeat injection based on prior trigger point injections providing significant relief. Per progress report dated 01/20/15, provider states, "After informed consent, the patient received four trigger-point injections. The patient reported good pain relief of greater than 50% and an increased range of motion a few minutes later." However, MTUS recommends repeat injection frequency should not be at an interval less than two months. These repeat injections on DOS 03/03/15 and 04/02/15 have been performed following 6 weeks and 4 weeks, respectively. Furthermore, the patient presents with radiculopathy. Per progress report dated 03/03/15 and 04/02/15, patient's assessment include bilateral lower extremity radiculopathy, left greater than right and physical examination reveals straight leg raise is

positive at about 60 degrees, which caused radicular symptoms to lower extremities. This request does not meet MTUS guidelines indication for Trigger Point Injections. Therefore, the request is not medically necessary.

Retro (DOS 4/2/15, 5/27/15): Follow up visit: Overturned

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), Low Back, Lumbar & Thoracic (Acute & Chronic) (2015).

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 & Lumbar & Thoracic (Acute & Chronic) Chapter, under Office visits.

Decision rationale: The patient presents with low back pain with radicular symptoms to both lower extremities, but right greater than left. The request is for Retro (DOS 4/2/15, 5/27/15): Follow up visit. The request for authorization is dated 04/02/15. MRI of the lumbar spine, 05/10/12, shows 4-mm disc protrusion at L2-3 with resulting abutment of the descending L3 nerve roots bilaterally and right and left L2 nerve roots; at L4-5 there is a 3-mm disc protrusion. EMG/NCV, 08/18/10, shows a mild acute L3 and L4 radiculopathy on the left. Physical examination of the posterior lumbar musculature reveals tenderness to palpation bilaterally with increased muscle rigidity. There are numerous trigger points that are palpable and tender throughout the lumbar paraspinal muscles. Decreased range of motion with obvious muscle guarding. Sensory exam with Wartenberg pinprick wheel is decreased along the posterior lateral thigh and posterior lateral calf in approximately the L5-S1 distribution. Straight leg raise is positive at about 60 degrees, which caused radicular symptoms to lower extremities. He has had extensive conservative management including undergoing lumbar epidural steroid injections with his last one performed on 04/09/12, which provided 60% pain relief, lasting a good 3-1/2 months. He feels that the combination of Anaprox, Topamax and Zanaflex enables him to keep his pain manageable as well as enable him to keep his Norco down to a minimum. He has also been experiencing less GI discomfort while on Prilosec, which he takes twice a day. He is able to perform simple chores around the house including cooking, cleaning and doing laundry. He has also been able to actively participate in the home exercise program with less discomfort. Patient's medications include Norco, Topamax, Neurontin, Naproxen, Prilosec and Xanax. Per AME report dated 05/12/15, the patient is not working. ODG-TWC Guidelines, Low Back & Lumbar & Thoracic (Acute & Chronic) Chapter, under Office visits Section states, "Recommended as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment." Per progress report dated 03/03/15 and 04/02/15, provider's reason for the request is "The patient will return to this office for follow-up in 1 month." In this case, ODG guidelines recommend office visits with the treating physician to review patient concerns, signs and symptoms. Therefore, the request is medically necessary.

Retro (DOS 4/2/15): Urine Drug Test QTY 1: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines steps to avoid misuse/addiction of opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic): Urine Drug Test (UDT) (2015).

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, under Urine drug testing (UDT).

Decision rationale: The patient presents with low back pain with radicular symptoms to both lower extremities, but right greater than left. The request is for Retro (DOS 4/2/15): Urine Drug Test QTY 1. The request for authorization is dated 04/02/15. MRI of the lumbar spine, 05/10/12, shows 4-mm disc protrusion at L2-3 with resulting abutment of the descending L3 nerve roots bilaterally and right and left L2 nerve roots; at L4-5 there is a 3-mm disc protrusion. EMG/NCV, 08/18/10, shows a mild acute L3 and L4 radiculopathy on the left. Physical examination of the posterior lumbar musculature reveals tenderness to palpation bilaterally with increased muscle rigidity. There are numerous trigger points that are palpable and tender throughout the lumbar paraspinal muscles. Decreased range of motion with obvious muscle guarding. Sensory exam with Wartenberg pinprick wheel is decreased along the posterior lateral thigh and posterior lateral calf in approximately the L5-S1 distribution. Straight leg raise is positive at about 60 degrees, which caused radicular symptoms to lower extremities. He has had extensive conservative management including undergoing lumbar epidural steroid injections with his last one performed on 04/09/12, which provided 60% pain relief, lasting a good 3-1/2 months. He feels that the combination of Anaprox, Topamax and Zanaflex enables him to keep his pain manageable as well as enable him to keep his Norco down to a minimum. He has also been experiencing less GI discomfort while on Prilosec, which he takes twice a day. He is able to perform simple chores around the house including cooking, cleaning and doing laundry. He has also been able to actively participate in the home exercise program with less discomfort. Patient's medications include Norco, Topamax, Neurontin, Naproxen, Prilosec and Xanax. Per AME report dated 05/12/15, the patient is not working. While MTUS Guidelines do not specifically address how frequent UDS should be considered for various risks of opiate users, ODG-TWC Guidelines, Pain (Chronic) Chapter, under Urine drug testing (UDT) Section, provide clear recommendation. It recommends once yearly urine drug screen following initial screening, with the first 6 months for management of chronic opiate use in low-risk patients. Per progress report dated 04/02/15, provider's reason for the request is "The patient is routinely monitored for "at risk" behavior with random urine drug screens." In this case, the patient's prescription includes Norco, which is an opioid pain medication. ODG recommends once yearly urine drug screen for management of chronic opiate use in low-risk patients. Therefore, the request is medically necessary.

Retro (DOS 4/7/15): Quantitative Testing QTY 1: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, under Urine drug testing (UDT).

Decision rationale: The patient presents with low back pain with radicular symptoms to both lower extremities, but right greater than left. The request is for Retro (DOS 4/7/15): Quantitative Testing QTY 1. The request for authorization is dated 04/02/15. MRI of the lumbar spine, 05/10/12, shows 4-mm disc protrusion at L2-3 with resulting abutment of the descending L3 nerve roots bilaterally and right and left L2 nerve roots; at L4-5 there is a 3-mm disc protrusion. EMG/NCV, 08/18/10, shows a mild acute L3 and L4 radiculopathy on the left. Physical examination of the posterior lumbar musculature reveals tenderness to palpation bilaterally with increased muscle rigidity. There are numerous trigger points that are palpable and tender throughout the lumbar paraspinal muscles. Decreased range of motion with obvious muscle guarding. Sensory exam with Wartenberg pinprick wheel is decreased along the posterior lateral thigh and posterior lateral calf in approximately the L5-S1 distribution. Straight leg raise is positive at about 60 degrees, which caused radicular symptoms to lower extremities. He has had extensive conservative management including undergoing lumbar epidural steroid injections with his last one performed on 04/09/12, which provided 60% pain relief, lasting a good 3-1/2 months. He feels that the combination of Anaprox, Topamax and Zanaflex enables him to keep his pain manageable as well as enable him to keep his Norco down to a minimum. He has also been experiencing less GI discomfort while on Prilosec, which he takes twice a day. He is able to perform simple chores around the house including cooking, cleaning and doing laundry. He has also been able to actively participate in the home exercise program with less discomfort. Patient's medications include Norco, Topamax, Neurontin, Naproxen, Prilosec and Xanax. Per AME report dated 05/12/15, the patient is not working. While MTUS Guidelines do not specifically address how frequent UDS should be considered for various risks of opiate users, ODG-TWC Guidelines, Pain (Chronic) Chapter, under Urine drug testing (UDT) Section, provide clear recommendation. It recommends once yearly urine drug screen following initial screening, with the first 6 months for management of chronic opiate use in low-risk patients. "Criteria for Use of Urine Drug Testing: If a urine drug test is negative for the prescribed scheduled drug, confirmatory testing is strongly recommended for the questioned drug." Per progress report dated 04/02/15, provider's reason for the request is "The patient is routinely monitored for "at risk" behavior with random urine drug screens." In this case, the UDS dated 04/02/15, shows an inconsistent result. Alprazolam, a schedule IV controlled substance is indicated and was not detected. ODG strongly recommends confirmatory testing if negative for prescribed scheduled drug. Therefore, the request is medically necessary.