

Case Number:	CM15-0143395		
Date Assigned:	08/06/2015	Date of Injury:	09/26/1999
Decision Date:	09/29/2015	UR Denial Date:	06/19/2015
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, Hawaii

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 58 year old female who sustained an industrial injury on 09-26-1999 resulting in injury to the knee. This caused a great deal of limping for which the injured worker subsequently developed low back pain. Treatment provided to date has included: L5-S1 disc replacement arthroplasty (2015); physical therapy; trigger point injections resulting in liver problems; percutaneous rhizotomies; acupuncture; right knee replacement surgery (2011); medications; and conservative therapies and care. Diagnostic tests performed include: x-rays of the lumbar spine (2015) showing fish mouthing of the vertebrae and some osteoporosis, and satisfactory placement and appearance of the disc replacement. Comorbidities included hypertension. There were no other dates of injury noted. On 06-04-2015, physician progress report noted decreasing sharp pain after undergoing a L5-S1 disc replacement arthroplasty approximately 1.5 months earlier. There was no specific complaints of pain, pain rating, list of current medications, or further objective findings noted on this report. A previous report (dated 04-23-2015) reported that the injured worker was 2 weeks post-op with some back pain, but no leg pain, numbness or tingling. No pain rating was noted. The physical exam revealed a clean and dry incision site, all deep tendon reflexes, motor and sensation were intact. There were no diagnoses mentioned. Plan of care (per the 06-04-22015 PR) includes physical therapy, Forteo 600mg with 5 refills, pan needles for administration, and follow-up. The injured worker's work status was not mentioned. The request for authorization and IMR (independent medical review) includes: Forteo 600mg #28 with 5 refills, and Pen needles #31 gauge 6mm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Forteo 600 mg #28 with 5 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Teriparatide (forteo) (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 Chapter on Teriparatide.

Decision rationale: The patient presents with lumbar spine pain. The patient is status post disc replacement from 04/10/2015. The current request is for Forteo 600mg #28 with 5 refills. The treating physician's report dated 06/04/2015 (16B) states, "Subsequent x-rays demonstrate fish mouting of the vertebrae and some osteoporosis. It would be important to treat this at this time since further softening of the bones could lead to subsidence and problems with the implant including fractures of the spine. I have suggested that she take Forteo once a day as a result of this". Medical records do not show a history of Forteo use. The MTUS and ACOEM Guidelines do not address this request. The ODG Guidelines under the Low Back Chapter on Teriparatide (Forteo) states, "Recommended as a second-line medication for patients at severe risk of vertebral compression fractures, or treatment of vertebral compression fractures, if they have failed in the past, or are unable to tolerate oral bisphosphonates. Not recommended for fracture repair or articular cartilage repair". Criteria includes: Females with severe post-menopausal osteoporosis, males with primary or hypogonadal osteoporosis, or adults with glucocorticoid- induced osteoporosis;- Bone mineral density (BMD) T score 2.5 or more - At high-risk for fractures - Failed (continued bone loss after 2 or more years on medications) or are unable totolerate either 2 oral bisphosphonates or 1 oral bisphosphonate plus 1 selective estrogen receptor modulator (SERM), or for whom oral bisphosphonate therapy is contraindicated. In this case, the patient does not have a diagnosis of hypogonadal osteoporosis. No bone density score was documented. The physician does not discuss whether or not the patient is at high-risk for fractures. Given that the patient does not meet the criteria based on the ODG guidelines, the current request is not medically necessary.

Pen needles #31 gauge 6mm: Upheld

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 Labor Code 4610.5-2- definition of medical necessity.

Decision rationale: The patient presents with lumbar spine pain. The patient is status post disc replacement from 04/10/2015. The current request is for Pen needles #31 gauge 6mm. The treating physician's report dated 06/04/2015 does not discuss the pen needles. It is unclear from the documentation why this request was made and what it is for. Labor Code 4610.5-2- definition of medical necessity. "Medically necessary" and "medical necessity" meaning medical

treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury". In this case, the medical necessity of the pen needles has not been established and is not in accordance to the Labor Code 4610.5-2. The current request is not medically necessary.

