

Case Number:	CM15-0146360		
Date Assigned:	08/07/2015	Date of Injury:	11/28/2001
Decision Date:	09/22/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/28/2015

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 57-year-old female, who sustained an industrial injury on 11-28-2001. The medical records submitted for this review did not include the details regarding the initial injury or prior treatments to date. Diagnoses include chronic low back pain, status post lumbar fusion. Currently, she complained of back pain with radiation to the right leg. Medications were noted to provide relief of pain from a "65 VAS down to a 23 VAS", increase function and quality of life, and for approximately six hours. On 5-20-15, the physical examination documented focal tenderness to the right sacroiliac joint and positive straight leg raise test on the right side. The plan of care included Omeprazole 20mg, #180 for three months maintenance; Butalbital 50-325- 40mg, #60 tablets for thirty-day supply; Hydrocodone 10-325mg #180, one to two month maintenance; and a sacroiliac joint injection with ultrasound guidance provided on this date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Omeprazole 20mg #180/3 months maintenance (DOS: 05/20/15):
 Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Proton Pump Inhibitors (PPIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 66-69.

Decision rationale: The IW is a 57 y. o. woman with a diagnosis of right SI pain. The request is for Omeprazole. The MTUS guidelines support the use of Omeprazole for gastric side effects due to NSAID use. MTUS Chronic Pain Medical Treatment Guidelines Pg 68-69 under NSAIDs, GI symptoms & cardiovascular risk, for Treatment of dyspepsia secondary to NSAID therapy states: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. Also, 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. In the medical records provided, none of the gastrointestinal risk factors is noted. The request is not medically necessary.

Retrospective request for Butalbital 50/325/40mg #60/1 month maintenance (DOS: 05/20/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbituates Page(s): 23.

Decision rationale: The IW is a 57 y. o. woman with diagnosis of SI pain and headaches. The request is for Butalbital 50/325/40 mg #60. The MTUS, under barbituate containing analgesic agents state, "Not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. (McLean, 2000) There is a risk of medication overuse as well as rebound headache. (Friedman, 1987) The medication is not recommended for use. The request is not medically necessary.

Retrospective request for Hydrocod/Acet 10/325mg #180/1-2 months maintenance (DOS: 05/20/15): Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-89.

Decision rationale: The IW presents with right SI pain and headaches. The current request is for Norco 10/325. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. " MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief.

In this case, the medical records adequately document the 4 A's, as required by the guidelines. The request is medically necessary.

Retrospective request for Asp/injection 1 unit, ultrasonic 1 unit, ultrasound 1 unit, marcaine .5% 2 units, ketorolac 2 units, dexamethasone 2 units (DOS: 05/20/15): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for the use of sacroiliac blocks.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pelvic/Hip.

Decision rationale: The IW presents with a history of right SI pain. OGD, pelvic/hip chapter states, "Criteria for the use of sacroiliac blocks: 1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). 2. Diagnostic evaluation must first address any other possible pain generators. 3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management. 4. Blocks are performed under fluoroscopy. (Hansen, 2003) 5. A positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed. 6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period. 7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. 8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block. 9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year. In this case, the medical records do not provide the 3 positive exam findings are required by ODG. The request is not medically necessary.