

Case Number:	CM15-0187700		
Date Assigned:	09/29/2015	Date of Injury:	11/04/2010
Decision Date:	12/01/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/23/2015

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: 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 41 year old female who sustained an industrial injury on 11-04-10. The assessment noted 8-3-15 is intervertebral disc disorder with myelopathy-lumbar region, post laminectomy syndrome lumbar region, thoracic or lumbosacral neuritis or radiculitis unspecified, degenerative lumbar-lumbosacral intervertebral disc, and lumbago. Previous treatment includes medication, massage, physical therapy, home exercise, nerve blocks, epidurals, and surgery. In a progress report dated 8-3-15, the physician notes a reported increase in low back pain intensity, with no change in distribution. Pain is rated 10 out of 10 without medications and 4-5 out of 10 with medication. She reports an increase in pain due to lumbar radiculopathy extending to right buttocks and right hip. It is noted that the medications prescribed are keeping her functional, allowing for increased mobility and tolerance of activities of daily living and home exercises. No side effects are reported. Lumbar-sacral exam reveals tenderness to palpation, forward flexion is 65 degrees, hyperextension is 10 degrees, bilateral lumbar spasms, and an antalgic gait. It is noted the most recent urine drug screen and (CURES) Controlled Substance Utilization Review and Escalation System was reviewed. A request for authorization is dated 8-19-15. On 8-27-15, the requested treatment of Lyrica 75mg #60 with 2 refills was modified to a partial certification of Lyrica 75mg #60 with no refills, and Oxycontin 40mg #60, Norco 10-325mg #180, MRI of the lumbar spine with contrast, X-Rays of the lumbar spine-7 views upright to include flexion-extension views, and replacement battery for power wheelchair were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 75mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: The request is for the use of a medication in the category of an anti-epileptic drug (AED). These medications are recommended for certain types of neuropathic pain. Most of the randomized clinical control trials involved include post-herpetic neuralgia and painful polyneuropathy such as in diabetes. There are few trials which have studied central pain or radiculopathy. The MTUS guidelines state that a good response to treatment is 50% reduction in pain. At least a 30% reduction in pain is required for ongoing use, and if this is not seen, this should trigger a change in therapy. There also should be documentation of functional improvement and side effects incurred with use. Disease states, which prompt use of these medications, include post-herpetic neuralgia, spinal cord injury, chronic regional pain syndrome, lumbar spinal stenosis, post-operative pain, and central pain. There is inadequate evidence to support use in non-specific axial low back pain or myofascial pain. In this case, there is lack of documentation of functional improvement or screening measures as required. As such, the request is not medically necessary.

OxyContin 40mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. As part of the pain treatment agreement, it is advised that "Refills are limited, and will only occur at appointments." In this case, there is inadequate documentation of persistent functional improvement seen. As such, the request is not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

Norco 10/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. As part of the pain treatment agreement, it is advised that "Refills are limited, and will only occur at appointments." In this case, there is inadequate documentation of persistent functional improvement seen. As such, the request is not certified. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

MRI of the lumbar spine with contrast: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Low Back Procedure Summary Online Version, updated 07/17/2015.

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)/ MRIs (magnetic resonance imaging).

Decision rationale: The request is for an MRI of the lumbar spine. The ODG guidelines state the following regarding qualifying criteria: Indications for imaging - Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit. Lumbar spine trauma: trauma, neurological deficit. Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit). Uncomplicated low back pain, suspicion of cancer, infection, other "red flags". Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Uncomplicated low back pain, prior lumbar surgery. Uncomplicated low back pain, cauda equina syndrome. Myelopathy (neurological deficit related to the spinal cord), traumatic. Myelopathy, painful. Myelopathy, sudden onset. Myelopathy, stepwise progressive. Myelopathy, slowly progressive. Myelopathy, infectious disease patient. Myelopathy, oncology patient. Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation) In this case, the patient would not qualify for an MRI based on the above set standards. This is secondary to a lack of a change in clinical status or described "red flags." There is a lack of documentation of progressive neurologic deficit. Pending further information revealing qualifying indications as listed above, the request is not medically necessary.

X-rays of the lumbar spine, 7 views upright to include flexion-extension views: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Low Back Procedure Summary Online Version updated 07/17/2015.

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/x-rays.

Decision rationale: The request is for x-rays of the low back. The ODG state the following regarding qualifying criteria: Not recommend routine x-rays in the absence of red flags. (See indications list below.) Indications for imaging - Plain X-rays: Thoracic spine trauma: severe trauma, pain, no neurological deficit. Thoracic spine trauma: with neurological deficit. Lumbar spine trauma (a serious bodily injury): pain, tenderness. Lumbar spine trauma: trauma, neurological deficit. Lumbar spine trauma: seat belt (chance) fracture. Uncomplicated low back pain, trauma, steroids, osteoporosis, over 70. Uncomplicated low back pain, suspicion of cancer, infection. Myelopathy (neurological deficit related to the spinal cord), traumatic. Myelopathy, painful. Myelopathy, sudden onset. Myelopathy, infectious disease patient. Myelopathy, oncology patient. Post-surgery: evaluate status of fusion. In this case, there is inadequate documentation of "red flags" which would warrant x-rays. There is also no record to indicate and change in neurologic status or new deficit. Pending this information, the request is not medically necessary.

Replacement battery for power wheelchair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.cms.hhs.gov/medlearn/powerwheelchair.pdf>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

Decision rationale: The request is for the use of a power mobility device. The MTUS guidelines state the following regarding this topic: Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. In this case, the use of a PMD is not indicated. This is secondary to inadequate documentation of a deficit would could not be resolved with a cane, walker, or manual wheelchair in this ambulatory patient. As such, the request is not medically necessary.