

Case Number:	CM15-0190198		
Date Assigned:	10/02/2015	Date of Injury:	11/03/2005
Decision Date:	12/07/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/28/2015

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: New York

Certification(s)/Specialty: Internal 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 57 year old female who sustained an industrial injury on 11-03-2005. Current diagnoses include chronic pain other, lumbar radiculopathy, right sided sacroiliac pain, and hypertension. Report dated 08-19-2015 noted that the injured worker presented with complaints that included low back pain with associated numbness in the right lower extremity, bladder dysfunction, urinary incontinence, and lower extremity pain. Pain level was 8 (with medications) and 10 (without medications) out of 10 on a visual analog scale (VAS). It was documented that "none of the medications help with pain, the pain is reported as recently worsened". It was also noted that the injured worker has difficulty utilizing a wheel chair due to right upper extremity rotator cuff injury. Physical examination performed on 08-19-2015 revealed spasms in the lumbar region, tenderness to palpation in the L4-S1 levels, limited range of motion in the lumbar spine secondary to pain, pain was increased with flexion and extension, decreased sensitivity in the L5-S1 dermatomes in the right, positive straight leg raise on the right, and sacroiliac joint testing was positive for tenderness bilaterally. Previous diagnostic studies included urine drug screens and multiple imaging. Previous treatments included medications, and injections. The treatment plan included administration of B12 injection and Toradol, continue home exercise program, request for an electric scooter, renewed medications, and follow up in one month. The injured worker has been prescribed Lyrica, Norco, and diclofenac ER since at least 04-29-2015. The utilization review dated 08-31-2015, non-certified the request for electric scooter, retrospective Toradol injection (DOS: 08/19/2015), and retrospective B12 injection (DOS: 08/19/2015) and modified the request for Lyrica, Norco, and diclofenac ER.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electric scooter: 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 Official Disability Guidelines (ODG) Knee/Leg Chapter, Motorized scooters, Power mobility devices (PMDs), Knee Chapter, Durable Medical Equipment.

Decision rationale: MTUS does not address this request. ODG recommends Durable Medical Equipment if there is a medical need and the device or system meets Medicare's definition of durable medical equipment (DME). Per ODG, motorized scooters are 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. Per guidelines, 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. The injured worker complains of chronic radicular low back pain and reports having rented a scooter privately for outings with family. Documentation indicates that the injured worker is ambulatory and there is lack of evidence of a functional mobility deficit or that a cane or walker has previously been prescribed. The medical necessity for an electric scooter has not been established. The request for Electric scooter is not medically necessary per guidelines.

Lyrica 150mg #90: 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 Official Disability Guidelines (ODG) Pain Chapter, Pregabalin (Lyrica).

Decision rationale: MTUS does not address this request. ODG recommends Lyrica (Pregabalin), an anti-convulsant, for treatment of neuropathic pain conditions and fibromyalgia, but not for acute pain. Lyrica has been FDA approved for the treatment of diabetic neuropathy, Fibromyalgia and postherpetic neuralgia. It has also been approved for neuropathic pain associated with spinal cord injury. The injured worker complains of chronic low back pain. Documentation fails to show significant objective improvement in pain or level of function to support the medical necessity for continued use of Lyrica. The request for Lyrica 150mg #90 is not medically necessary per guidelines.

Norco 10/325mg #60: Upheld

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

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

Decision rationale: MTUS recommends that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented with the use of Opioids. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guidelines recommend using key factors such as pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors, to monitor chronic pain patients on opioids. Assessment for the likelihood that the patient could be weaned from opioids is recommended if there is no overall improvement in pain or function, unless there are extenuating circumstances and if there is continuing pain with the evidence of intolerable adverse effects. The injured worker complains of chronic radicular low back pain. Documentation fails to demonstrate adequate objective improvement in level of function or pain, to support the medical necessity for continued use of opioids. In the absence of significant response to treatment, the request for Norco 10/325mg #60 is not medically necessary.

Diclofenac ER 100mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Per MTUS, Non-steroidal anti-inflammatory drugs (NSAIDS) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. There is no evidence of long-term effectiveness for pain or function. NSAIDS are recommended as a second-line treatment after acetaminophen for the treatment of acute exacerbations of chronic low back pain. The injured worker's symptoms are chronic and ongoing, without evidence of significant objective improvement in pain with ongoing use of this long acting NSAID. With MTUS guidelines not being met, the request for Diclofenac ER 100mg #60 is not medically necessary.

Retrospective Toradol 60mg injection (DOS: 08/19/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain and Shoulder Chapters, Ketorolac (Toradol).

Decision rationale: MTUS states that Non-steroidal anti-inflammatory drugs (NSAIDs) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. There is no evidence of long-term effectiveness for pain or function. Per guidelines, Toradol injection is indicated in the management of moderately severe acute pain as an alternative to opioid therapy. It is not recommended for chronic painful conditions. Toradol injection may also be administered as an option to corticosteroid injections for shoulder pain, with up to three injections. It is recommended that patients receiving Ketorolac injections not take concurrent oral NSAIDs due to potential side effect of bleeding. Documentation provided for review indicates that the injured worker complains of chronic low back pain treated over three times so far, with Toradol injection to date. Physician reports also demonstrate concurrent NSAID use. There is lack of evidence of significant objective improvement in pain or function on current medication regimen. With MTUS guidelines not being met, the request for Retrospective Toradol 60mg injection (DOS: 08/19/2015) is not medically necessary by guidelines.

Retrospective B12 1000mcg injection (DOS: 08/19/2015): 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 Official Disability Guidelines (ODG) Pain Chapter, B vitamins & vitamin B complex.

Decision rationale: MTUS does not address this request. ODG does not recommend the use of Vitamin B complex for the treatment of chronic pain unless this is associated with documented vitamin deficiency. Treatment of vitamin B12 deficiency is generally by injection. It is frequently used for treating peripheral neuropathy but its efficacy is not clear. The injured worker complains of chronic low back pain. Documentation provided for review fails to show a diagnosis of associated Vitamin B deficiency to establish the medical necessity for Vitamin B12 injection. The request for Retrospective B12 1000mcg injection (DOS: 08/19/2015) is not medically necessary.