MAXIMUS Federal Services

Case Number:	CM15-0201115		
Date Assigned:	10/16/2015	Date of Injury:	06/17/2010
Decision Date:	12/23/2015	UR Denial Date:	10/02/2015
Priority:	Standard	Application Received:	10/13/2015

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: Pediatrics, 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:

This is a 51 year old male with a date of injury of June 17, 2010. A review of the medical records indicates that the injured worker is undergoing treatment for chronic lower back pain with radiculopathy to the left lower extremity. Medical records dated July 15, 2015 indicate that the injured worker complained of lower back pain radiating to the left hip, left thigh, and left knee rated at a level of 4 out of 10, 9 out of 10 at its worst, and 2 out of 10 at its best. A progress note dated September 16, 2015 documented complaints similar to those reported on July 15, 2015. Per the treating physician (July 15, 2015), the employee was permanent and stationary. The physical exam (May 13, 2015; July 15, 2015; September 16, 2015) reveals a non-antalgic gait, and no changes in this follow up visit (previous objective findings were not documented in the submitted records). Treatment has included lumbar epidural steroid injection (July 9, 2015) with some benefit, medications (Tramadol since at least February of 2015; Percocet since at least May of 2015; Neurontin and Ibuprofen), unknown number of physical therapy sessions, The urine drug screen dated July 15, 2015 showed results that were inconsistent with the injured worker's prescribed medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Flexeril 10mg #90 (DOS: 9/16/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

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

Decision rationale: Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. The greatest effect appears to be in the first 4 days of treatment. The documentation does not reference muscle spasm that the Flexeril would be used for and at this time frame it is not indicated. This request is not medically necessary.

Bilateral lumbar medial branch block: 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), Low Back-Lumbar & Thoracic (Acute & Chronic), Facet joint medial branch blocks (therapeutic injections).

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 - Facet joint intra-articular injections (therapeutic blocks), Facet joint diagnostic blocks (injections).

Decision rationale: Per ACOEM guidelines the criteria for use of therapeutic intra-articular and medial branch blocks are no more than one therapeutic intra-articular block is recommended, there should be no evidence of radicular pain, spinal stenosis, or previous fusion, if successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive), no more than 2 joint levels may be blocked at any one time and there should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy. According to the documentation the epidural steroid injection but there is no notation as to how much pain relief was achieved or how long the pain relief lasted. Without documentation of 6 weeks or more of significant pain relief the request is not medically necessary.

Retrospective request for Percocet 7.5/325mg #30 (DOS: 9/16/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Weaning of Medications.

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

Decision rationale: The IW is documented to be on an opioid for pain relief. Documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary.

Retrospective request for Tramadol 50mg #90 (DOS: 9/16/15): Upheld

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

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

Decision rationale: The IW is documented to be on an opioid for pain relief. Documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary.