

Case Number:	CM15-0028421		
Date Assigned:	02/20/2015	Date of Injury:	06/23/2005
Decision Date:	04/06/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/16/2015

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: Preventive Medicine, Occupational 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 44 year old male who sustained an industrial injury on 6/23/05 from a slip and fall with onset of pain in the left hand, wrist, left leg low back and neck. He is currently experiencing constant, severe low back pain shooting down both legs, left more than right with tingling, numbness and paresthesia and left leg weakness. His pain intensity is 7-8/10. Medications include naproxen, Neurontin, Flexaril. He has stomach upset with medications. Diagnoses are left paracentral disc protrusion at L5-S1 with bulge at L4-5; left sided L5-S1 lumbar radiculopathy; status post left scaphoid fracture; lumbar spondylosis and chronic myofascial pain syndrome. Diagnostics included x-rays to affected areas (2005); electromyography/nerve conduction studies (12/19/14) revealing left sided L5-S1 lumbar radiculopathy. The progress note dated 1/12/15 indicates that because of the constant pain, the treating provider is requesting left sided L5-S1 transforaminal and translaminar epidural steroid injection. In addition he is requesting Protonix for the stomach upset and continue on current medications. On 1/28/15 Utilization review non-certified the requests for one left sided L5-S1 transforaminal and translaminar epidural steroid injection; Protonix 20 mg; Naproxen 550 mg; and Flexaril 7.5 mg citing MTUS: Chronic Pain medical treatment Guidelines: Epidural Steroid Injection; MTUS: Chronic pain Medical Treatment Guidelines respectively.

IMR ISSUES, DECISIONS AND RATIONALES

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

Protonix 20 mg: 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 Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 9792.26, Page 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (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. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor Protonix 20 mg.

One left sided L5-S1 transforaminal and translaminar epidural steroid injection with epidurogram: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 9792.26, Page 46.

Decision rationale: According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The medical record does contain documentation of radiculopathy which is corroborated by imaging studies. I am reversing the previous utilization review decision. One left sided L5-S1 transforaminal and translaminar epidural steroid injection with epidurogram is medically necessary.

Naproxen 550 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 9792.26, Pages 67-73.

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term

effectiveness for pain or function. The medical record contains no documentation of functional improvement. Naproxen 550 mg is not medically necessary.

Flexeril 7.5 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 9792.26, Page 64.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants such as cyclobenzaprine. The patient has been taking cyclobenzaprine for an extended period, long past the 2-3 weeks recommended by the MTUS. Flexeril 7.5 mg is not medically necessary.