

Case Number:	CM15-0031423		
Date Assigned:	02/24/2015	Date of Injury:	07/26/2013
Decision Date:	04/10/2015	UR Denial Date:	02/16/2015
Priority:	Standard	Application Received:	02/19/2015

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: Anesthesiology

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 53 year old male, who sustained an industrial injury on 07/26/2013. He has reported low back pain. The diagnoses have included lumbar radiculopathy; lumbar spine herniated nucleus pulposus with stenosis at L5-S1; and facet arthropathy of lumbar spine. Treatment to date has included medications, lumbar epidural steroid injection, and chiropractic treatment. Medications have included Norco, Gabapentin, and Cyclobenzaprine. A progress note from the treating physician, dated 01/12/2015, documented a follow-up visit with the injured worker. The injured worker reported lower back pain, rated 6/10 on the visual analog scale; episodes of severe spasms in the back 2-3 times a day; numbness in the bilateral posterior thighs, with tingling radiating down to his feet; and pain improves with medications and chiropractic sessions. Objective findings included tenderness to palpation over the lower lumbar facet regions bilaterally and in the lumbar paraspinous regions; severe pain with facet loading of the lumbar spine; and decreased lumbar range of motion. The treatment plan has included requests for transforaminal lumbar epidural steroid injection, additional chiropractic visits, prescription medications, and pain management consultation. On 02/16/2015, Utilization Review non-certified 1 prescription of Gabapentin 600 mg #30; Cyclobenzaprine 7.5 mg #60; Norco 10/325 mg #120; Transforaminal epidural injection on left L5 and S1; and Pain management consultation. The CA MTUS and the ODG were cited. On 02/19/2015, the injured worker submitted an application for IMR for review of Gabapentin 600 mg #30; Cyclobenzaprine 7.5 mg #60; Norco 10/325 mg #120; Transforaminal epidural injection on left L5 and S1; and Pain management consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 600mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs (AED) Page(s): 17-19, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gabapentin.

Decision rationale: According to the CA MTUS (2009) and ODG, Gabapentin (Neurontin) is an anti-epilepsy drug (AED), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. This medication appears to be effective in reducing abnormal hypersensitivity (allodynia and hyperalgesia), to have anti-anxiety effects, and may be beneficial as a sleep aid. There is limited evidence to show that this medication is effective for postoperative pain. In this case, there is patient documentation of a increase in pain relief (by 50%), and an increase in functional improvement (increase in walking by 20 minutes). Medical necessity of the requested Gabapentin has been established. The requested medication is medically necessary.

Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

Decision rationale: Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant with similar effects to tricyclic antidepressants. It has a central mechanism of action, but it is not effective in treating spasticity from cerebral palsy or spinal cord disease. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Cyclobenzaprine is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. This medication is not recommended to be used for longer than 2-3 weeks. In this case, there is documentation of functional improvement, however, this medication is not recommended to be used for longer than 2-3 weeks. Based on the currently available information, the medical necessity for Cyclobenzaprine has not been established. The requested medication is not medically necessary.

Norco 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Criteria for Use Page(s): 91-97, 88-89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opiate should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Transforaminal epidural injection on left L5 and S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of epidural steroid injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: A selective nerve root block, or transforaminal epidural steroid injection (ESI), is a variation of the traditional midline ESI; the spinal nerve roots exit the spine laterally. Based on a patient's medical history, a physical exam, and MRI findings, often a specific inflamed nerve root can be identified. According to the CA MTUS guidelines, criteria for ESI's include the following: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing; initially unresponsive to conservative treatment; and no more than two nerve root levels should be injected using transforaminal blocks. The documentation reported that the patient had low back pain with episodes of severe spasms 2-3 times a day; numbness in the bilateral posterior thighs with tingling radiating down to his feet. Pain improved with medications and chiropractic sessions. This patient will first undergo (8) additional certified chiropractic treatments. The Medical necessity of the requested left L5-S1 transforaminal ESI using fluoroscopy has not been established at this time. The requested service is not medically necessary.

Pain management consultation: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Office Visits.

MAXIMUS guideline: Decision based on MTUS ACOEM.

Decision rationale: ACOEM states that consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. This case involves a request for a Pain Management consultation. This patient has a chronic pain condition that requires specialty and coordinated care. This patient has continued pain that has not been responsive to ongoing therapy, pending additional chiropractic sessions. Therefore, a Pain Management consultation would be indicated. Medical necessity for the requested Pain Management consultation has been established. The requested service is medically necessary.