

Case Number:	CM15-0037872		
Date Assigned:	03/06/2015	Date of Injury:	07/11/2000
Decision Date:	05/01/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/27/2015

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 71 year old male who sustained an industrial injury on 07/11/2000. Diagnoses include possible peripheral neuropathy of unclear etiology, status post lumbar surgery, and lumbar complaints. Treatment to date has included medications, surgery and diagnostics. A physician progress note dated 01/13/2015, documents the injured worker complains of back stiffness, numbness in the right and left leg, and radicular pain in the right and left leg. On examination, the lumbosacral exam reveals positive pelvic thrust bilateral, pain with Valsalva, positive Faber maneuver on the left, positive Gaenslen's maneuver on the right, positive Patrick's maneuver bilateral, and secondary myofascial pain with triggering bilateral and positive stork test bilateral. Treatment requested are for Bilateral Sacroiliac Injection Lumbar Spine, Colace 250mg #60 with 3 refills, Cymbalta 30mg #30 with 3 refills, Evaluation with [REDACTED], Lyrica 50mg #180 with 3 refills, Occupational Therapy Lumbar Spine, quantity 12, and Physical Therapy Lumbar Spine, quantity 12. On 01/27/2015, Utilization Review partially certified the request for Bilateral Sacroiliac Injection Lumbar Spine and cited was ODG-TWC. The request for Physical Therapy Lumbar Spine, quantity 12 was non-certified and cited was MTUS, ACOEM Guidelines. The request for Occupational Therapy Lumbar Spine, quantity 12 was non-certified and cited was CA MTUS, ACOEM Guidelines. The evaluation with [REDACTED] was certified and cited was CA MTUS Guidelines. The request for Colace 250mg #60 with 3 refills was denied and cited was CA MTUS Guidelines. Cymbalta 30mg #30 with 3 refills was non-certified and cited was CA MTUS Guidelines. Lyrica 50mg #180 with 3 refills was denied and cited was CA MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Sacroiliac Injection Lumbar Spine: 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) TWC Chapter Hip & pelvis (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Sacroiliac injections.

Decision rationale: Sacroiliac joint injections (SIJ) are recommended as an option if the patient has failed at least 4-6 weeks of aggressive conservative therapy. In this case, the physical exam demonstrated bilateral SIJ tenderness. There has been documentation of 4-6 weeks of aggressive conservative therapy with no improvement. In addition, this patient underwent a previous sacroiliac injection in 2007 with apparent relief. The documentation supports that the patient is symptomatic despite conservative treatments. Medical necessity for the requested service has been established. The requested bilateral SIJ injections are medically necessary.

Physical Therapy Lumbar Spine, quantity 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Chapter Low Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: According to the California MTUS Treatment Guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, the patient has completed previous physical therapy sessions. There is no documentation of the number of sessions completed, or documentation indicating that the patient had a defined functional improvement in his condition from previous physical therapy. There is no specific indication for the requested additional PT sessions. Medical necessity for the requested sessions has not been established. The requested services are not medically necessary.

Occupational Therapy Lumbar Spine, quantity 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Chapter Low Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Occupational therapy/Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical medicine is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, the patient has completed previous physical therapy sessions. There is no documentation of the number of sessions completed, or documentation indicating that the patient had a defined functional improvement in his condition from previous physical therapy. There is no specific indication for the requested occupational therapy (OT) sessions. There is no documentation of any type of a significant event that has led to a flare-up of symptoms unresponsive to a home exercise program and medications to support OT sessions. Medical necessity for the requested services has not been established. The requested services are not medically necessary.

Evaluation with [REDACTED]: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM.

Decision rationale: The CA MTUS/ACOEM guidelines state that a consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, permanent residual loss and/or the injured worker's fitness to return to work. In this case, the sacroiliac injection has been certified by [REDACTED], the Pain Management consultant. Medical necessity for the requested consultation is established. The requested consultation is medically necessary.

Cymbalta 30mg #30 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants: SNRIs Page(s): 13, 15-16.

Decision rationale: According to the California MTUS Guidelines, antidepressants are indicated for the treatment of chronic pain. They are recommended as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. The documentation does not indicate the patient has neuropathic pain. Per the documentation, the use of Cymbalta in this patient's medical regimen has not proven beneficial. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Colace 250mg #60 with 3 refills: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Constipation.

Decision rationale: Opioid-induced constipation is a common adverse effect of long-term opioid use because of the binding of opioids to peripheral opioid receptors in the gastrointestinal tract, resulting in absorption of electrolytes and reduction in small intestine fluid. According to ODG, if opioids are determined to be appropriate for the treatment of pain then prophylactic treatment of constipation should be initiated. In this case, there is no documentation of constipation and the patient is not maintained on opioid analgesics. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

Lyrica 50mg #180 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): 58.

Decision rationale: According to California MTUS Guidelines, anti-epilepsy medications are a first-line treatment for neuropathic pain. Lyrica is FDA approved for diabetic neuropathy and post-herpetic neuralgia, and has been used effectively for the treatment of other neuropathic pain. In this case, this patient has low back pain (LBP) without documentation of neuropathic pain. Lyrica has been used in the past. However, there is no documentation that guidelines have been met. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.