

Case Number:	CM14-0109338		
Date Assigned:	08/01/2014	Date of Injury:	07/17/2000
Decision Date:	12/03/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/14/2014

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. The expert reviewer is Board Certified in Emergency Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient reported an injury on 7/17/2000. No mechanism of injury was provided for review. Patient has a diagnosis of lumbar disc degeneration, lumbosacral spondylosis and lumbar spinal stenosis. Patient is post lumbar laminectomy pre-date of injury. Medical reports reviewed. Last report available until 6/25/14. Several more recent reports up to 10/1/14 were sent as well. Unless the information in those charts directly pertains to the request under review, those charts were not reviewed since prospective information does not retrospectively change criteria used for independent medical review as per MTUS guidelines. Patient complains of low back and neck pain associated with numbness to legs and feet. Pain worsened with movement. Pain is 6/10 and occurs up to 65% of day limiting activity. Objective exam reveals cervical and lumbar paraspinal pain and spasms. Range of motion is decreased. Palpation of R Piriformis muscle with tenderness with palpable band and twitch response. Note reports 60% improvement in pain with last injection in 1/21/14 lasting 3months. Patient is reportedly undergoing physical therapy. No medication list was provided for review. Records reveal that patient is on Allopurinol, Fluoxetine, Gabitril, Lovastatin and Ultram. Independent Medical Review is for Right Piriformis Trigger Point Injection and Gabitril #30. Prior UR on 6/30/14 recommended non-certification. It approved prescription for Ultram.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Piriformis Trigger Point Injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: Trigger Point Injections may be recommended only for myofascial pain syndrome if patient meets criteria as set by MTUS Chronic pain guidelines. However, the documentation reports that patient fails to meet repeat Trigger Point Injections. Patient does not have a diagnosis of myofascial pain or Piriformis syndrome. Patient has known history of spinal stenosis and other causes for chronic back pain. Guidelines require documentation of at least 50% improvement in objective pain and function from prior injection. Documentation claimed "65%" improvement is not an objective measurement in improvement in pain or function. This request for trigger point injections does not meet appropriate criteria for approval without appropriate objective documentation of prior improvement and its use in the appropriate diagnosis. Trigger Point Injection of R Piriformis is not medically necessary.

Gabitril #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.nlm.nih.gov

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs(AEDs) Page(s): 18-19.

Decision rationale: Gabitril or tiagabine is an anti-epileptic drug (AED) FDA approved for partial seizures. It is occasionally used off label for neuropathic pain. As per MTUS Chronic pain guidelines, AEDs may be used for neuropathic pain; however, multiple of other AEDs are recommended as 1st line treatment with better evidence compared to Gabitril. It is not known why the provider has decided to use this medication instead of other 1st line medications. The provider has also documented no improvement in pain or function with this medication but worsening pain. Gabitril is not medically necessary.