

Case Number:	CM14-0119185		
Date Assigned:	08/06/2014	Date of Injury:	05/02/2003
Decision Date:	10/10/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/29/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in Nevada. 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:

The records presented for review indicate that this 64 year-old male was reportedly injured on May 2 2003. The most recent progress note, dated July 28, 2014, indicates that there are ongoing complaints of low back pain with lower 7 radiation. The physical examination demonstrated a decrease in range of motion, positive straight leg raising and sensory changes in the L5 nerve root distribution on the left. Diagnostic imaging studies objectified lumbar changes. Previous treatment includes cervical spine surgery, epidural steroid injections, multiple medications, physical therapy, and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on July 7, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat transforaminal lumbar epidural steroid injection (L) L4-L5 under sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of epidural steroid injections.

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

Decision rationale: Based on the progress notes presented for review, the injured employee had an exacerbation of low back pain that would require an emergency room evaluation and an

injection of analgesic medication. A rush epidural steroid injection was completed in length of time, the efficacy of this injection was noted is less than several weeks. There is no letter diagnostic evidence of a verifiable radiculopathy, and there is no clear indication previous injections were efficacious. As noted in the MTUS a 2nd block is not recommended if there is inadequate response to the 1st block. Therefore, when noting the date of injury, the injury sustained, the current clinical examination reported tempered by the parameters outlined in the MTUS this is not medically necessary.

Norco 10/325 mg, #120 (DOS 06/09/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

Decision rationale: When noting the date of injury, the surgery completed, the frequency of the medications and that there is no objectification that there is any increased functionality, decrease the pain complaints, or any other parameter demonstrating that there is some utility with medication protocol there is little clinical information presented to support this request. As outlined in the MTUS the lowest possible dose to increase functionality and decrease pain complaints is to be used. Seeing no specific parameters outlined in the progress notes demonstrating the efficacy or utility of this medication, there is no clinical indication for continuing this medication.

Tizanidine 4 mg, #120 (DOS 06/09/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha 2-adrenergic agonist that is FDA approved for management of spasticity. It is unlabeled for use in low back pain. Muscle relaxants are only indicated as 2nd line options for short-term treatment. It appears that this medication is being used on a chronic, long-term or indefinite basis which is not supported by MTUS treatment guidelines. Furthermore, there is no data in the progress notes indicating that this medication is achieving its intended result. Therefore, this medication is not medically necessary.

Naprosyn 550 mg, #120 (DOS 06/09/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS in the treatment of chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66 & 73.

Decision rationale: While noting that this is an option as outlined in the MTUS, this is for the relief of symptoms assigned to osteoarthritis. Given the date of injury, it is clear that the medication is not being used to address the osteoarthritis rather other pathologies. Given the ongoing pain complaints there is no demonstration in the progress notes how this medication is supporting the injured worker or achieving its intended goal. Therefore, based on the lack of clinical information tempered by the parameters outlined in the MTUS this is not medically necessary.