

<b>Case Number:</b>	CM14-0092950		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	02/14/2005
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2014

### 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 62 year-old individual was reportedly injured on 2/14/2005. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated 5/28/2014, indicates that there are ongoing complaints of low back pain. The physical examination demonstrated: ambulates with a steady gait without use of assistive devices, performs transfer slowly and decreased range of motion of the back. No recent diagnostic studies are available for review. Previous treatment includes medications, acupuncture, and conservative treatment. A request had been made for lumbar epidural steroid injection, Kenalog injection, and was non-certified in the pre-authorization process on 6/13/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar epidural steroid injection with fluoroscopic spine or ultrasound guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

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

**Decision rationale:** MTUS guidelines support epidural steroid injections when radiculopathy is documented on physical examination and corroborated by imaging and electrodiagnostic studies

in individuals who have not improved with conservative care. Based on the clinical documentation provided, there is insufficient clinical evidence that the proposed procedure meets the MTUS guidelines. Specifically, there is no documentation of (radiculopathy on physical exam). As such, the requested procedure is deemed not medically necessary.

**Kenalog injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

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

**Decision rationale:** MTUS guidelines support epidural steroid injections when radiculopathy is documented on physical examination and corroborated by imaging and electrodiagnostic studies in individuals who have not improved with conservative care. Based on the clinical documentation provided, there is insufficient clinical evidence that the proposed procedure meets the MTUS guidelines. Specifically, there is no documentation of (insert omitted data here). As such, the requested procedure is deemed not medically necessary.

**Lidocaine injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** As outlined in the ACOEM guidelines, local injections and facet injections are of questionable merit. It is noted that they have been used for occasional short-term improvement in the wall pain situation. However, based on the clinical information presented for review, tempered by the parameters outlined in the guidelines, the medical necessity for this intervention has not been established.

**Omnipaque:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** It is noted that the injection therapies are not warranted. As such, there is no indication for radiopaque dye. The medical necessity is not been established.

**Injection tray:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** It is noted that the underlying injection therapies are not medically necessary. As such, the injection tray is not medically necessary.

**Sedation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** In that the requested injection therapies are not medically necessary, sedation to perform this procedure is not medically necessary.

**Omeprazole 20mg #180 with 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** This is a protein pump inhibitor useful for the treatment of gastroesophageal reflux disease. This can also be used as a protectorate against the side effects of some non-steroidal medications. The progress notes presented did not indicate there are any complaints of gastric distress or side effects with the medication. As such, the clinical indication for this medication has not been established.

**Creon 12000 units #120 with 6 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 Page(s): 68.

**Decision rationale:** A search of the MTUS, ACOEM and Official Disability Guidelines do not result in any findings relative to this product. This is a pancreatic lipase supplement and there is no clinical indication presented of the need for this medication whatsoever. This medication is not addressed in the most recent progress notes presented for review. This is not medically necessary based off the information presented for review.

**Dexilant 60mg #30 with 6 refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** The progress notes indicate that there are gastrointestinal issues being addressed for this medication. As such, based on the most recent data, there is a clinical indication to provide a proton pump inhibitor to address the gastroesophageal reflux disease. Therefore, this request is medically necessary.

**Norco 10/325mg #50:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

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

**Decision rationale:** Norco is a short acting opioid indicated for the management of moderate to severe breakthrough pain. The most recent medical records indicate that approximately 50 tablets a month are being used. However, there is no notation of any functional improvement, decrease pain, or other utility relative to the utilization of this medication. The guidelines require that there need to be assessed of the functional status and that the appropriate medication use (i.e. lowest possible dose) is employed. Given the lack of clinical information, this is not medically necessary.

**Midazolam (Versed):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Therefore, based on the clinical information presented for review, tempered by the parameters noted in the MTUS for benzodiazepines, this is not medically necessary.

**14 acupuncture sessions:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13 of 127.

**Decision rationale:** When noting the date of injury, the injury sustained, and the response to a similar intervention previously, there is insufficient clinical information presented to support this request. As noted in the MTUS, this can be used as an option however there must be objectification of functional improvement as a result of this intervention. This was not presented in the medical records. Therefore, this is not medically necessary.