

Case Number:	CM14-0210121		
Date Assigned:	12/23/2014	Date of Injury:	11/29/2004
Decision Date:	02/19/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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: California

Certification(s)/Specialty: Physical Medicine & Rehabn

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 patient is a 55-year-old female with date of injury of 11/29/2004. The listed diagnoses from 11/13/2014 are: 1. Thoracic or lumbosacral neuritis or radiculitis. 2. Degeneration of the lumbar or lumbosacral intervertebral disk. 3. Sacroiliitis. 4. Chronic pain syndrome. According to this report, the patient complains of bilateral hip and low back pain. She rates her pain without medication 6/10 to 8/10 and with medication, 4/10. She reports benefit with her current pain medication, enabling her to keep her pain within a manageable level and to allow her to complete necessary activities of daily living. Examination shows low back pain radiating to the right hip, lateral leg, and lateral foot. Intermittent numbness, tingling, burning of the right calf and foot was noted. Moderate TTP diffusely over the lumbosacral region and severe TTP over the right SI joint. Straight leg raise is positive bilaterally eliciting pain over the SI joint as well as the L3-L5 paraspinal musculature. Flexion and lateral bending is normal. Extension is limited to 50 degrees. Dyesthesia noted along the lateral right ankle and foot. Normal DTRs. Treatment reports from 09/24/2013 to 11/13/2014 were provided for review. The utilization review modified the request for Norco and denied the rest of the requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right sacroiliac joint steroid injection (1st injection): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) hip and pelvis chapter on sacroiliac joint injection

Decision rationale: The patient presents with bilateral hip and low back pain. The treater is requesting a right sacroiliac joint steroid injection (1st injection). The MTUS and ACOEM Guidelines do not address this request. However, ODG Guidelines, under the hip and pelvis chapter on sacroiliac joint injection, recommends SI joint injection as an option if the patient has 3 positive exam findings for SI joint syndrome; diagnostic evaluation has addressed other possible pain generators; at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercises, and medication management. The records do not show any previous right sacroiliac joint injection. None of the reports document any of the required 3 positive exam findings for SI joint syndrome. In this case, the patient does not meet the criteria set by ODG for a sacroiliac joint injection. The request is not medically necessary.

Replacement of transcutaneous electrical nerve stimulation (TENS) unit with supplies for purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 8; 114-116.

Decision rationale: The patient presents with bilateral hip and low back pain. The treater is requesting replacement of TENS unit with supplies for purchase. The MTUS Guidelines page 114 to 116 on TENS unit state that it is not recommended as a primary treatment modality but a 1-month home based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. The 09/24/2013 report notes that the patient continues to use a TENS unit for "symptomatic management". Aside from this statement, there is no discussion as to how the patient is utilizing the TENS unit, how often, and with what results. The treater is requesting a replacement unit because the patient's current TENS unit is worn out. MTUS page 8 on chronic pain require satisfactory response to treatment including increased levels of function, decreased pain or improved quality of life. In this case, it is uncertain if patient is benefiting from the use of a TENS unit. Given the lack of documented efficacy while utilizing a TENS unit, the request is not medically necessary.

MRI of the lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter on MRI

Decision rationale: This patient presents with bilateral hip and low back pain. The treater is requesting an MRI of the lumbar spine. The ACOEM Guidelines page 303 on MRI for back pain state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery as an option. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. ODG also states that repeat MRIs are not routinely recommended and should be reserve for significant change in symptoms and/or findings suggestive of significant pathology (e.g. tumor, infection, fracture, nerve compression, and recurrent disk herniation). The records do not show any previous MRI of the lumbar spine. The 11/13/2014 report notes that the patient has low back pain radiating to the right hip, lateral leg, and lateral foot. There is intermittent numbness, tingling, and burning of the right lateral calf and foot. Straight leg raise is positive bilaterally eliciting pain over the SI joint as well as the L3-L5 paraspinal musculature. Dysesthesia was noted along the lateral right ankle and foot. In this case, the patient does present with significant clinical findings and an MRI is supported by the guidelines. The request is medically necessary.

Flector patches 1.3 percent #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: This patient presents with bilateral hip and low back pain. The treater is requesting Flector patches 1.3 percent #30. The MTUS Guidelines on topical analgesics page 111 to 113 state that topical non-steroidal anti-inflammatory drugs (NSAIDs) are highly recommended for peripheral joint osteoarthritis/tendinitis like problem. These medications may be used for chronic musculoskeletal pain but there are no long-term studies of their effectiveness or safety. The records do not show history of Flector patch use. The treater does not provide a rationale for the request. Given that the patient does not present with peripheral joint osteoarthritis/tendinitis, the request is not medically necessary.

Norco 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medication for chronic pain; on-going management; opioids Page(s): 60-61, 78, 88-89.

Decision rationale: This patient presents with bilateral hip and low back pain. The treater is requesting Norco 10/325mg quantity #180. For chronic opiate use, the MTUS guidelines page 88 and 89 on criteria for use of opioids state, "pain should be assessed at each visit, and functioning should be measured at six-month intervals using a numerical scale or validated instrument." MTUS page 78 On-Going Management also require documentation of the 4A's including analgesia, activities of daily living (ADLs), adverse side effects, and aberrant drug seeking behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medications to work, and duration of pain relief. The records show that the patient was prescribed Norco on 09/24/2013. The treater notes that the patient's pain with medication is 4/10 and without medication is 6/10 to 8/10. The patient reports benefit with his medication maintenance regimen, enabling her to keep pain within a manageable level, allowing her to complete necessary activities of daily living. The treater does not provide specifics regarding ADLs, no change in work status or return to work to show significant functional improvement. No side effects and no aberrant drug-seeking behaviors such as urine drug screen and CURES report were noted. Given the lack of sufficient documentation demonstrating efficacy for chronic opiate use, the patient should now be slowly weaned as outlined in the MTUS Guidelines. The request is not medically necessary.