

Case Number:	CM14-0210581		
Date Assigned:	12/23/2014	Date of Injury:	10/04/2012
Decision Date:	02/19/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	12/16/2014

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 45-year old female with an injury date on 10/04/2012. Based on the 12/02/2014 progress report provided by the treating physician, the diagnoses are: 1. Cervical sprain2. Lumbosacral sprain3. Post traumatic headaches4. Post traumatic sleep disruption5. Whiplash syndromeAccording to this report, the patient complains of ongoing pain in her neck and low back. She is more symptomatic with her back pain and left leg pain. Physical exam of the lumbar spine reveals tenderness at the bilateral paraspinal muscles. Range of motion is restricted. The treatment plan is to request for Lumbar Epidural Steroid Injection at left L4-5 level per QME request, request for Gastroenterology consultation, refill medication and patient is to return for follow up as PRN. The patient's work status is "Permanent and Stationary per QME. The 8/29/2014 QME report indicates there is tenderness at the lumbosacral junction. Straight leg raise and Laseque test are positive on the left. Faber test is positive, bilaterally. Per QME provider, MRI of the lumbar spine on 02/06/2013 and 07/06/2013 shows a 3mm broad leftward bulge or protrusion with mild to moderate left neutral foraminal stenosis" at L4-L5 and a 3mm posterior bulge or protrusion at L5-S1. Reports of the 2 MRI of the lumbar spine were included in the file for review. There were no other significant findings noted on this report. The utilization review denied the request for (1) LESI at L4/5, (2) Tramadol #120 with 2 refills, and (3) Temazepam 30mg #30 with 2 refills on 12/12/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 06/02/2014 to 12/02/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Lumbar Epidural Steroid Injection at left L4-5 level: 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 lumbar ESI Page(s): 46 and 47.

Decision rationale: According to the 12/02/2014 report, this patient presents with "ongoing pain in her neck and low back." Per this report, the current request is for 1 Lumbar Epidural Steroid Injection at left L4-5 level. Regarding ESI, MTUS guidelines states "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." For repeat injections, MTUS requires "continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. In reviewing the provided reports does not show prior lumbar epidural steroid injections. MRI of L-spine indicates that the patient has a 3mm disc bulge at L4-L5 and positive Straight leg raise, Laseque test, and Faber test. However, the pain is not described in a specific dermatomal distribution to denote radiculopathy or nerve root pain as required by the MTUS guideline. Therefore, the current request is not medically necessary.

1 prescription of Tramadol 50mg #120 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain; CRITERIA FOR USE OF OPIOIDS Page(s): 60,61;76-78;88-89.

Decision rationale: According to the 12/02/2014 report, this patient presents with "ongoing pain in her neck and low back." Per this report, the current request is for 1 prescription of Tramadol 50mg #120 with 2 refills. This medication was first mentioned in the 06/02/2014 report; it is unknown exactly when the patient initially started taking this medication. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and aberrant 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 medication to work and duration of pain relief. Per QME report that patient "is uncomfortable doing her personal hygiene and activities of daily living and getting dressed and undressed but she can do them herself. She can perform her household chores but is limited due to her injuries. She has to watch what she is doing so she does not get worse. She cannot play golf because it involved too much twisting which aggravates her back. In reviewing the provided reports, there is documentation of ADL's as mentioned above. However, there is no documentation of pain

assessment using a numerical scale describing the patient's pain. The treating physician does not discuss outcome measures as required by MTUS. No valid instruments are used to measure the patient's function which is recommended once at least every 6 months per MTUS. UDS was not obtained. No discussion regarding other opiates management issues such as CURES and behavioral issues. The treating physician has failed to properly document analgesia, Adverse effects and Adverse behavior as required by MTUS. Therefore, the current request is not medically necessary.

1 prescription of Temazepam 30mg #30 with 2 refills: Upheld

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

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

Decision rationale: According to the 12/02/2014 report, this patient presents with "ongoing pain in her neck and low back. Per this report, the current request is for 1 prescription of Temazepam 30mg #30 with 2 refills. The MTUS and ACOEM guidelines do not discuss this medication; however, ODG Guidelines states that Temazepam is FDA-approved benzodiazepines for sleep maintenance insomnia include estazolam (ProSom), flurazepam (Dalmane), quazepam (Doral), and Temazepam (Restoril). Triazolam (Halcion) is FDA-approved for sleep-onset insomnia. These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events. In reviewing the provided reports, the treating physician does not document that the patient has depression or sleep disturbance and requested Temazepam #0 with 2 refills and does not mention that this is for a short-term use. The patient has been prescribed this medication since 06/02/2014. ODG Guidelines does not recommend long-term use of this medication. Therefore the current request is not medically necessary.