

Case Number:	CM14-0213323		
Date Assigned:	12/30/2014	Date of Injury:	08/22/2009
Decision Date:	03/11/2015	UR Denial Date:	11/28/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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: Preventive Medicine, Occupational Medicine

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 is a 57 year-old female with date of injury 08/22/2009. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 11/12/2014, lists subjective complaints as pain in the low back. MRI of the lumbar spine on 10/26/2009 was notable for disc herniation at L4-L5 causing moderate spinal stenosis. Objective findings: Examination of the lumbar spine revealed tenderness to palpation across the lumbosacral junction. Patient had bilateral paraspinal spasms from L5 level up to the L2 level. Decreased flexion and extension. Diagnosis: 1. Low back pain with radiculopathy. 2. Status post lumbar decompressive surgery at L4-L5, 02/12/2014. The medical records supplied for review document that the patient has been taking the following medication for at least as far back as six months. Medication: 1. Prilosec 20mg, #30 SIG: QD. 2. Zoloft 100mg, #30 SIG: QD.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Prilosec 20mg #30 is not medically necessary.

Zoloft 100mg #30 (dispensed on 11/12/14): 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): 13.

Decision rationale: Sertraline (trade names Zoloft, Lustral) is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. The MTUS recommends antidepressants as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain, but tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. There is no documentation in the medical record that tricyclics have been ineffective, poorly tolerated, or contraindicated. Zoloft 100mg #30 (dispensed on 11/12/14) is not medically necessary.

Trial of Botox injections 300 units for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Integrated Treatment/disability Duration Guidelines- Low Back- Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25-26.

Decision rationale: According to the MTUS, Botox is not generally recommended for chronic pain disorders, but recommended for cervical dystonia. Botox is not recommended for the following: tension-type headache; migraine headache; fibromyositis; chronic neck pain; myofascial pain syndrome; & trigger point injections. Consideration may be given to using Botox for: chronic low back pain, if a favorable initial response predicts subsequent responsiveness, as an option in conjunction with a functional restoration program. The medical record does not document the criteria necessary to warrant the use of Botox. Trial of Botox injections 300 units for the lumbar spine is not medically necessary.

6 post injections physical therapy visits for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration /Physical Medicine Page(s): 7 / 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, the injections are not authorized; consequently, physical therapy is not medically necessary.

Urine drug screen: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Integrated Treatment/ Disability Duration Guidelines- Pain (Chronic)- Urine Drug Testing (UDT)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

Decision rationale: The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. There is no documentation in the medical record that a urine drug screen was to be used for any of the above indications. Urine drug screen is not medically necessary.