

Case Number:	CM14-0071837		
Date Assigned:	08/08/2014	Date of Injury:	06/26/2001
Decision Date:	06/01/2015	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/19/2014

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, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker is a 52 year old female, who sustained an industrial injury on June 26, 2001. The injured worker was diagnosed as having lumbar facet joint pain, spasm of muscle, thoracic or lumbosacral neuritis or radiculitis, lumbar region postlaminectomy syndrome, chronic pain syndrome, hip pain, degeneration of lumbar or lumbosacral intervertebral disc, and dysesthesia. Treatment to date has included trigger point injections, MRI, x-rays, chiropractic treatments, activity restrictions, failed spinal cord stimulator trial, and medication. The injured worker presented on 01/31/2014 for a follow-up evaluation regarding right sided lower back pain. The injured worker reported 6/10 chronic low back pain with intermittent radiating symptoms into the bilateral lower extremities. The injured worker also reported daily right lower extremity muscle spasms involving the great toe. The current medication regimen includes MS Contin 60 mg, Norco 10/325 mg, Zanaflex 4 mg, and Neurontin 600 mg. Upon examination of the lumbar spine, there was limited flexion to 20 degrees, limited extension, diffuse right lumbar/bilateral buttock tenderness, maximum tenderness near the right PSIS, significant bilateral lumbar paraspinal muscle spasm, positive right sided supine straight leg raise at 30 degrees, and a well healed long vertical scar in the lumbar spine. Treatment recommendations at that time included continuation of the current medication regimen, an MRI of the lumbar spine and SI joints, an MRI of the thoracic spine, a lumbar epidural steroid injection, and 4 to 6 visits of chiropractic treatment. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MS Contin 60mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker has continuously utilized MS Contin 60 mg since at least 10/2013. There is no documentation of objective functional improvement. The injured worker continues to report high levels of pain. There is also no frequency listed in the request. As such, the request is not medically necessary.

Neurontin (Gabapentin) 600mg #180 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19.

Decision rationale: The California MTUS Guidelines state gabapentin is recommended for neuropathic pain. In this case, the injured worker has continuously utilized the above medication since at least 10/2013. There is no documentation of objective functional improvement. The injured worker continues to report high levels of pain with intermittent radiating, burning, tingling, and numbness in the bilateral lower extremities. There is also no frequency listed in the request. As such, the request is not medically necessary.

MRI Lumbar Spine SI joints without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. In this case, there was no documentation of a significant musculoskeletal or neurological deficit upon examination. There was no evidence of the emergence of any red flags. There is no documentation of a significant change or

progression of symptoms or examination findings. The medical necessity for the requested imaging study has not been established. Therefore, the request is not medically necessary.

MRI Thoracic Spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back and Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. In this case, there was no documentation of a significant musculoskeletal or neurological deficit upon examination. There was no evidence of the emergence of any red flags. There is no documentation of a significant change or progression of symptoms or examination findings. The medical necessity for the requested imaging study has not been established. Therefore, the request is not medically necessary.

Lumbar Epidural Steroid Injection L2-3: Upheld

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

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

Decision rationale: The California MTUS Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, there was no documentation of a recent attempt at any conservative treatment in the form of active rehab. The medical necessity for a lumbar epidural steroid injection at the L2-3 level has not been established. Given the above, the request is not medically necessary.