

Case Number:	CM15-0004384		
Date Assigned:	01/15/2015	Date of Injury:	01/13/2012
Decision Date:	03/10/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/08/2015

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: Emergency 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:

The injured worker is a 43 year old female who suffered a work relate injury on 01/13/12. Per the physician report on 12/11/14, she complains of low back pain which radiates to her bilateral lower extremities, worse on the right side. Her treatment plan includes lumbar ESI, cold therapy unit for purchase, Norco, and tizanidine. The Claims Administrator non-certified the lumbar ESI, Norco, tizanidine, and a compound of tramadol/ gabapentin/menthol/camphor/capsaicin per MTUS guidelines on 12/31/14. The cold therapy unit was non-certified citing ACOEM guidelines. The non-certified treatments were subsequently appealed for Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): Pages.

Decision rationale: The requested Norco 10/325mg #60, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has lower back pain with radiation to both lower extremities, along with numbness and tingling. The treating physician has documented lumbar and facet tenderness, decreased right L3-S1 sensation, decreased lower extremity muscle strength and positive straight leg raising tests. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Norco 10/325mg #60 is not medically necessary.

Tizanidine 4mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page 63-66 Page(s): Pages 63-66.

Decision rationale: CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants, Page 63-66, do not recommend muscle relaxants as more efficacious than NSAIDs and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has lower back pain with radiation to both lower extremities, along with numbness and tingling. The treating physician has documented lumbar and facet tenderness, decreased right L3-S1 sensation, decreased lower extremity muscle strength and positive straight leg raising tests. The treating physician has not documented spasticity or hypertonicity on exam, intolerance to NSAID treatment, nor objective evidence of derived functional improvement from its previous use. The criteria noted above not having been met, Tizanidine 4mg #60 is not medically necessary.

1 Continued compound analgesic cream: tramadol 8%/gabapentin 10%/menthol 2%/camphor 2%/capsaicin .05%, 120 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and

anticonvulsants". The injured worker has lower back pain with radiation to both lower extremities, along with numbness and tingling. The treating physician has documented lumbar and facet tenderness, decreased right L3-S1 sensation, decreased lower extremity muscle strength and positive straight leg raising tests. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, 1 Continued compound analgesic cream: tramadol 8%/gabapentin 10%/menthol 2%/camphor 2%/capsaicin .05%, 120 gm is not medically necessary.

1 lumbar epidural steroid injection at L4-5 and L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines p. 46, Epidural steroid injections (ESIs) Page(s): Page 46.

Decision rationale: Chronic Pain Medical Treatment Guidelines, p. 46, Epidural steroid injections (ESIs) note the criteria for epidural injections are "1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)." The injured worker has lower back pain with radiation to both lower extremities, along with numbness and tingling. The treating physician has documented lumbar and facet tenderness, decreased right L3-S1 sensation, decreased lower extremity muscle strength and positive straight leg raising tests. The treating physician has not documented full failed trials of conservative therapy nor imaging studies confirming specific level radiculopathy. The criteria noted above not having been met, 1 lumbar epidural steroid injection at L4-5 and L5-S1 is not medically necessary.

1 Post-injection motorized cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 161. 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 ODG, Shoulder, Continuous Flow Cryotherapy

Decision rationale: CA MTUS is silent on this issue and ODG, Shoulder, Continuous Flow Cryotherapy, recommends up to 7 days post-op cold therapy. In a post-operative setting, cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The injured worker has lower back pain with radiation to both lower extremities, along with numbness and tingling. The treating physician has documented lumbar and facet tenderness, decreased right L3-S1 sensation, decreased lower extremity muscle strength and positive straight leg raising tests. The treating physician has not documented the medical necessity for cold therapy beyond seven days usage. The criteria noted above not having been met, 1 Post-injection motorized cold therapy unit is not medically necessary.

