

Case Number:	CM15-0127416		
Date Assigned:	07/14/2015	Date of Injury:	03/10/2013
Decision Date:	09/16/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	07/01/2015

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: 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:

The injured worker (IW) is a 72 year old male who sustained an industrial injury on 03/10/2013. The mechanism of injury and initial report of injury are not found in the records reviewed. The injured worker was diagnosed as having: Lumbar radiculopathy secondary to lumbar disk herniation L4-L5. Lumbar facet syndrome, bilateral at L4-5 and L5-S1. History of coronary artery disease, currently treated and stable (non-industrial). Treatment to date has included conservative care of courses of anti-inflammatory medications, analgesics, and physical therapy. Currently, the injured worker complains of severe low back and bilateral leg pain with numbness and weakness non-responsive to conservative treatments. The examination confirms neurological sensory deficits along L4, loss of the right patellar tendon reflex, and reduction of the right Achilles tendon reflex. A MRI of 06/06/2014 revealed a L4-5 broad based asymmetrical disc bulging of 2mm with documented bilateral facet joint and ligamentum flavum hypertrophy and encroachment of the exiting nerve roots bilaterally by the disk and facet disease. A request for authorization was made for the following: 1. Tramadol 50 MG #60. 2. Ibuprofen 300 MG #90. 3. Dendracin Lotion #1 Tube. 4. Outpatient Lumbar ESI Bilateral L4/5 Under Fluoroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Section, Weaning of Medications Section Page(s): 74-95, 124.

Decision rationale: Tramadol is a central acting synthetic opioid that exhibits opioid activity with a mechanism of action that inhibits the reuptake of serotonin and norepinephrine with side effects similar to traditional opioids. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. In this case, the injured worker has been taking Tramadol for an extended period without objective evidence of functional improvement. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Tramadol 50 MG #60 is determined to not be medically necessary.

Ibuprofen 300 MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Section Page(s): 67-71.

Decision rationale: The use of NSAIDs are recommended by the MTUS Guidelines with precautions. NSAIDs are recommended to be used secondary to acetaminophen, and at the lowest dose possible for the shortest period in the treatment of acute pain or acute exacerbation of chronic pain as there are risks associated with NSAIDs and the use of NSAIDs may inhibit the healing process. The injured worker has chronic injuries with no change in pain level and no acute injuries reported and has been taking NSAIDs in a chronic nature without measurable functional improvement. The request for Ibuprofen 300 MG #90 is determined to not be medically necessary.

Dendracin Lotion #1 Tube: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin Topical Section, Topical Analgesics Section Page(s): 28, 29, 111-113.

Decision rationale: Dendracin lotion contains the active ingredients methyl salicylate 30%, capsaicin 0.0375%, and menthol 10%. The use of topical analgesics are recommended as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The MTUS Guidelines recommend the use of topical capsaicin only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indications that this increase over a 0.025% formulation would provide any further efficacy. Since capsaicin 0.0375% is not recommended by the guidelines, the use of Dendracin lotion is not recommended. The request for Dendracin lotion #1 tube is determined to not be medically necessary.

Outpatient Lumbar ESI Bilateral L4/5 Under Fluoroscopy: Overturned

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

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

Decision rationale: Epidural steroid injections are recommended by the MTUS Guidelines when the patient's condition meets certain criteria. The criteria for use of epidural steroid injections include; 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment. 3) Injections should be performed using fluoroscopy for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed, and a second block is not recommended if there is inadequate response to the first block. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on 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. 8) No more than 2 ESI injections. In this case, there is objective evidence of radicular pain on physical examination and radiculopathy is corroborated by imaging studies. The request for outpatient lumbar ESI bilateral L4/5 under fluoroscopy is determined to be medically necessary.