

Case Number:	CM15-0141923		
Date Assigned:	07/31/2015	Date of Injury:	10/26/2011
Decision Date:	10/09/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/21/2015

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: Texas, New York, 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 applicant is a represented 56-year-old who has filed a claim for chronic low back pain (LBP) reportedly associated with an industrial injury of October 26, 2011. In a Utilization Review report dated June 24, 2015, the claims administrator failed to approve requests for injectable Toradol, injectable dexamethasone, injectable Depo Medrol, oral Naprosyn, oral Flexeril, oral Imitrex, and oral Protonix apparently prescribed, dispensed, and/or administered on or around June 8, 2015. The applicant's attorney subsequently appealed. On said June 8, 2015 progress note, the applicant reported multifocal complaints of low back and shoulder pain. The applicant was no longer working, it was acknowledged, and had reportedly "retired," the treating provider contended. Naprosyn, Flexeril, Norco, and Protonix were prescribed and/or dispensed without any seeming discussion of medication efficacy. Injections of Toradol, dexamethasone, and Depo Medrol were given, again without any clear rationale as to why these injections were administered. The applicant's permanent work restrictions were renewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Toradol injection 60mg/ml DOS 6-8-15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, specific drug list & adverse effects. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 3rd ed., Chronic Pain, pg. 942 [A] single dose of ketorolac appears to be a useful alternative to a single moderate dose of opioids for the management of patients presenting to the ED with severe musculo- skeletal LBP.

Decision rationale: No, the request for a Toradol injection administered on June 8, 2015 was not medically necessary, medically appropriate, or indicated here. While the MTUS does not address the topic of injectable Toradol, page 72 of the MTUS Chronic Pain Medical Treatment Guidelines notes that oral ketorolac or Toradol is not indicated for minor or chronic painful conditions. By analogy/implication, injectable ketorolac or Toradol was likewise not indicated for minor or chronic painful conditions. Here, there was no mention of the applicant's having experienced any acute flares in symptoms on or around the date in question, June 8, 2015. While the Third Edition ACOEM Guidelines Chronic Pain Chapter does acknowledge that injectable ketorolac or Toradol represents a useful alternative to a single moderate dose of opioids for applicants who present to the Emergency Department with severe musculoskeletal low back pain, here, again, the June 8, 2015 progress note at issue made no mention of the applicant's having experienced any acute flare in symptomatology on or around the date in question. Rather, it appeared that the applicant was given an injection of Toradol for chronic pain complaints, without any evidence of the applicant's having suffered an acute flare on or around the date in question. Such usage, however, was at odds with both page 72 of the MTUS Chronic Pain Medical Treatment Guidelines and with page 942 of the Third Edition ACOEM Practice Guidelines Chronic Pain Chapter. Therefore, the request was not medically necessary.

Retrospective Dexamethasone injection 20mg/ml DOS 6-8-15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation; MDconsult.com.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Introduction.

Decision rationale: Similarly, the request for a retrospective dexamethasone injection administered on June 8, 2015 was likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 3, page 48, injections of corticosteroids should be reserved for applicants who do not improve with more conservative therapies as steroid injections can weaken tissues and predispose toward injury. Here, however, a clear rationale for provision of the dexamethasone injection in the face of the tepid ACOEM position on the same was not furnished. Page 7 of the MTUS Chronic Pain Medical Treatment Guidelines further stipulates that an attending provider should incorporate some discussion of applicant-specific variables such as "other medications" into his choice of pharmacotherapy. Here, however, the attending provider's June 8, 2015 progress note did not clearly state why the applicant was receiving two concomitant steroid injections for Depo Medrol and dexamethasone on the same date, June 8, 2015. Therefore, the request was not medically necessary.

Retrospective Depo-Medrol injection 40mg /ml DOS 6-8-15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Low Back.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Introduction.

Decision rationale: Similarly, the request for a Depo Medrol injection administered on June 8, 2015 was likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 3, page 48, injections of corticosteroids should be reserved for applicants who do not improve with more conservative therapies, as steroids can weaken tissues and predispose toward injury. Here, the attending provider failed to furnish a clear or compelling rationale for a Depo Medrol injection in the face of the tepid ACOEM position on the same. The attending provider failed to furnish a rationale on June 8, 2015 so as to support administration of the injection in question. Page 7 of the MTUS Chronic Pain Medical Treatment Guidelines further stipulates that an attending provider should incorporate some discussion of applicant-specific variables such as "other medications" into his choice of pharmacotherapy. Here, however, the attending provider failed to furnish a clear or compelling rationale for concomitant administration of two separate steroid injections, namely injectable Depo Medrol and injectable dexamethasone on the same date, June 8, 2015. Therefore, the request was not medically necessary.

Retrospective Anaprox 550mg quantity 60 DOS 6-8-15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Introduction, Anti-inflammatory medications.

Decision rationale: Similarly, the request for Anaprox (naproxen), an antiinflammatory medication, was likewise not medically necessary, medically appropriate, or indicated here. While page 22 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that anti-inflammatory medications such as naproxen (Anaprox) do represent the traditional first line of treatment for various chronic pain conditions, including the chronic low back pain reportedly present here, this recommendation is, however, qualified by commentary made on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines and on page 47 of the ACOEM Practice Guidelines to the effect that an attending provider should incorporate some discussion of "efficacy of medication" into his choice of recommendations. Here, however, the applicant was no longer working, it was acknowledged on June 8, 2015. Ongoing use of naproxen failed to curtail the applicant's dependence on opioid agents such as Norco. The attending provider's June 8, 2015 progress note failed to outline quantifiable decrements in pain and meaningful, material improvements in function (if any) effected as a result of ongoing naproxen usage. All of the foregoing, taken together, suggested a lack of functional improvement as defined in MTUS 9792.20e, despite ongoing usage of the same. Therefore, the request was not medically necessary.

Retrospective Imitrex 100mg quantity 9 DOS 6-8-15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Head.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Introduction. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Triptans and Other Medical Treatment Guidelines U.S. Food and Drug Administration IMITREX® (sumatriptan succinate) 173 INDICATIONS AND USAGE 174 IMITREX Tablets are indicated for the acute treatment of migraine attacks with or without 175 aura in adults.

Decision rationale: Similarly, the request for Imitrex was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines and on page 47 of the ACOEM Practice Guidelines, it is incumbent upon a prescribing provider to incorporate some discussion of "efficacy of medication" into his choice of recommendations. While the attending provider did state on June 8, 2015 that Imitrex was in fact being employed for migraine headaches, a condition for which it is recommended both by the FDA label and by ODGs Head Chapter Triptans topic, the attending provider's June 8, 2015 progress note, however, failed to state whether or not ongoing usage of Imitrex had or had not proven effective in attenuating symptoms of migraine headaches if and when they arose. No seeming discussion of medication efficacy transpired on the June 8, 2015 office visit in question. It was not clearly established whether or not ongoing usage of Imitrex had or had not proven effective in attenuating symptoms of migraine headaches. Little-to-no commentary on the frequency and severity of migraine headaches and/or the effect that Imitrex was having on the same transpired. Therefore, the request was not medically necessary.

Retrospective Flexeril 7.5mg quantity 90 DOS 6-8-15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Non Sedating Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: Similarly, the request for Flexeril (cyclobenzaprine) was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 41 of the MTUS Chronic Pain Medical Treatment Guidelines, the addition of cyclobenzaprine or Flexeril to other agents is not recommended. Here the applicant was in fact using a variety of other agents, including Naprosyn, Norco, Imitrex, etc., it was acknowledged on June 8, 2015. The addition of cyclobenzaprine to the mix was not recommended. It is further noted that the 90-tablet supply of Flexeril (cyclobenzaprine) at issue, in and of itself, represents treatment in excess of the "short course of therapy" for which cyclobenzaprine is recommended, per page 41 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.

Retrospective Protonix 20mg quantity 60 DOS 6-8-15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Finally, the request for Protonix, a proton pump inhibitor, was likewise not medically necessary, medically appropriate, or indicated here. While page 69 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that proton pump inhibitors such as Protonix are indicated in the treatment of NSAID-induced dyspepsia, here, however, the June 8, 2015 progress note made no mention of the applicant's having any issues with reflux, heartburn, and/or dyspepsia, either NSAID-induced or stand-alone. Therefore, the request was not medically necessary.