

Case Number:	CM15-0142848		
Date Assigned:	07/31/2015	Date of Injury:	03/12/2010
Decision Date:	10/09/2015	UR Denial Date:	07/09/2015
Priority:	Standard	Application Received:	07/23/2015

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 is a 55-year-old male who sustained an industrial injury on 3-12-10. In a follow up pain management consultation and review of medical records dated 9-20-11, the physician notes the injured worker continues with severe ongoing debilitating pain in his lower back radiating down to both lower extremities. He was evaluated by a neurosurgeon and is considering surgical intervention. Previous treatment noted includes 2 epidural steroid injections bilaterally at L4-L5 on November 2010 and January 2011, providing 70% pain relief lasting approximately 3 months, stretching exercises, physical therapy, non-steroidal anti-inflammatory drugs, and muscle relaxants. He has lumbar disc disease with 4-5 mm disc protrusions at L2-L3 and L4-L5 and documented L3-L4 radiculopathy on electrodiagnostic study that was done on 8-18-10. Medications noted this visit, are Norco, Neurontin, Zanaflex, Topamax and Dendracin topical cream. The injured worker is requesting trigger point injections at this visit as they provide at least 2 weeks of temporary relief. Lumbar spine range of motion is decreased and straight leg raise in the modified sitting position is positive bilaterally at approximately 60 degrees. The assessment noted is lumbar myoligamentous injury with severe degenerative disc disease and foraminal narrowing, bilateral lower extremity radiculopathy- left greater than right, and obesity. In a progress note dated 4-28-11, the treating physician notes medications as Norco, Anaprox, Neurontin and "D. Cream" and indicates a treatment plan of a transcutaneous electrical nerve stimulation unit and "hot-cold". The requested treatment is retrospective (date of service 4-28-11, 9-20-11) Norco 10-325mg #60, retrospective (date of service 4-28-11, 9-20-11) Anaprox 550mg #60, retrospective (date of service 4-28-11, 9-20-11) Zanaflex 4mg #60, retrospective

(date of service 6-1-11, 10-31-11) follow up visit, retrospective (date of service 9-20-11) 4 trigger point injections, retrospective (date of service 5-13-11) Interferential Unit, retrospective (date of service 5-13-11) Micro Cool Unit, retrospective (date of service 5-13-11), Cold Therapy Unit, retrospective (date of service 5-13-11) Vital Wrap System, retrospective (date of service 4-28-11) Urine Drug Screen test, retrospective (date of service 4-28-11) Neurontin 600mg #60, and retrospective (date of service 9-20-11) Topamax 25mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro (DOS 4/28/11, 9/20/11) Norco 10/3235mg #60: 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): Opioids for chronic pain.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Therefore, the request is not medically necessary.

Retro (DOS 4/28/11, 9/20/11): Anaprox DS 550mg #60: 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 (non-steroidal anti-inflammatory drugs).

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The medical record contains no documentation of functional improvement. Therefore, the request is not medically necessary.

Retro (DOS 4/28/11, 9/20/11): Zanaflex 4mg #60: 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): Muscle relaxants (for pain).

Decision rationale: Tizanidine or Zanaflex is a drug that is used as a muscle relaxant. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. In addition, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. The patient has been taking the muscle relaxant for an extended period of time. Therefore, the request is not medically necessary.

Retro (DOS 9/20/11): 4 Trigger Point Injections: 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): Trigger point injections.

Decision rationale: Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. The MTUS states that trigger point injections are recommended only for myofascial pain syndrome with limited lasting value and not recommended for radicular pain. Patient has had previous trigger point injections but has not noted any significant functional improvement or pain relief as a result. Therefore, the request is not medically necessary.

Retro (DOS 5/13/11): Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic): Interferential Therapy (2015).

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

Decision rationale: The MTUS does not recommend a TENS unit as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. There is no documentation that a trial period with a rented TENS unit has been completed. Therefore, the request is not medically necessary.

Retro (DOS 5/13/11): Micro Cool Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Cold/heat packs.

Decision rationale: According to the Official Disability Guidelines, there is minimal evidence supporting the use of cold therapy except in the acute phase of an injury or for the first seven days postoperatively. Based on the patient's stated date of injury, the acute phase of the injury has passed. Therefore, the request is not medically necessary.

Retro (DOS 5/13/11): Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic): Cold/heat packs (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Continuous-flow cryotherapy.

Decision rationale: The Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for nonsurgical treatment. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. At present, based on the records provided, and the evidence-based guideline review, the request is not medically necessary.

Retro (DOS 5/13/11): Vital Wrap System: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Cold/heat packs.

Decision rationale: According to the Official Disability Guidelines, there is minimal evidence supporting the use of cold therapy except in the acute phase of an injury or for the first seven days postoperatively. The injury is long past the acute phase and the unit is not ordered for postoperative purposes. Therefore, the request is not medically necessary.

Retro (DOS 4/28/11): Urine Drug Screen Test: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic): Urine drug testing (UDT) (2015).

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

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. Therefore, the request is not medically necessary.

Retro (DOS 4/28/11): Neurontin 600mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs).

Decision rationale: The MTUS states that gabapentin is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. An adequate trial period for gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. With each office visit, the patient should be asked if there has been a change in the patient's pain symptoms, with the recommended change being at least 30%. There is no documentation of any functional improvement. Therefore, the request is not medically necessary.

Retro (DOS 9/20/11): Topamax 25mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar & Thoracic (Acute & Chronic): Topiramate (Topamax).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs).

Decision rationale: Topamax is an anti-epilepsy drug sometimes recommended for neuropathic pain, i.e. pain due to nerve damage. Randomized controlled studies have been limited in regard to central pain, and there have been none for painful radiculopathy. If an antiepileptic drug is prescribed for a patient for other than painful polyneuropathy or postherpetic neuralgia, a first-line medication such as gabapentin or pregabalin should be tried initially. The patient complains of central-type and radicular pain. The medical record lacks documentation that the patient has been tried on any first-line agents. Therefore, the request is not medically necessary.