

Case Number:	CM15-0160460		
Date Assigned:	08/26/2015	Date of Injury:	06/25/2001
Decision Date:	12/09/2015	UR Denial Date:	08/04/2015
Priority:	Standard	Application Received:	08/17/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 56 year old, female who sustained a work related injury on 6-25-01. The diagnoses have included status post multiple lumbar fusions, lumbar discogenic disease, chronic low back pain and instability spondylolisthesis L2-3 Grade II. Treatments have included home exercises, oral medications, activity modifications, physical therapy and prolonged rest. Medications she is currently taking are Percocet, Klonopin, and Neurontin. In the progress notes dated 6-24-15, the injured worker reports increased low back for about a month. She rates the pain level a 10 out of 10 without medications and states the pain is constant and severe. With medications, she states her pain decreases, her function increases and is more active. With the medications, she has about a 75% improvement. She can do housework, sit in her car, and she can stand longer. She can do some light exercise. Upon physical exam, she has spasms in the lumbar area. She has a positive Lasegue sign. She has numbness on the left leg across S1. She has left leg sciatica at 60 degrees. She has decreased sensation on the left S1 dermatome. Her symptoms, functional capabilities and physical exams have not changed much with the last few progress notes. She is not working. The treatment plan includes refills of medications, for a lumbar epidural steroid injections, for a Toradol lumbar trigger point injection, and for a lumbar brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Toradol 60mg injection x1: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Ketorolac (Toradol) is a non-steroidal anti-inflammatory drug (NSAID). The oral form is only recommended for short-term (up to 5 days) management of moderately severe acute pain that requires analgesia at the opioid level, and only as a continuation following IV or IM dosing, if necessary. This medication is not indicated for minor or chronic painful conditions. The guidelines do not recommend Toradol for chronic pain, as in this case. Medical necessity for a Toradol injection has not been established. The requested medication is not medically necessary.

Klonopin 1mg #30: 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): Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Benzodiazepines.

Decision rationale: According to CA MTUS Guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Clonazepam (Klonopin) is a long-acting benzodiazepine, having anxiolytic, sedative, and hypnotic properties. Most guidelines recommend the use of Clonazepam for the treatment of anxiety disorders, and as an adjunct treatment for anxiety associated with major depression. Use of this medication is limited to four weeks. There are no guideline criteria that supports the long-term use of benzodiazepines. In this case, there was no documentation of the indication and duration of use. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Percocet 10/325mg #180: 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, Opioids, dosing, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and the ODG, Percocet (Oxycodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. In addition, the MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no documentation of symptomatic benefit, improved pain level, functional improvement, or ability to return to work with previous opioid treatment. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Lumbar Brace: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Supports.

Decision rationale: According to ODG, lumbar supports are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). According to MTUS/ACOEM guidelines, lumbar support braces have not been shown to have lasting benefit beyond the acute phase of symptom relief. In this case, this patient has had chronic low back pain complaints, and a lumbar support brace is not warranted. Medical necessity for the requested lumbar support brace has not been supported or established. The requested item is not medically necessary.

Lumbar Epidural Steroid Injection L5-S1: 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): Epidural steroid injections (ESIs).

Decision rationale: Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). ESIs can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs is to reduce pain and inflammation,

restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. According to the CA MTUS guidelines, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, clarification is required since a left L5-S1 ESI was already authorized and there is no documentation of the results or any interpretation of previous imaging studies. Medical necessity for the requested lumbar ESI has not been established. The requested ESI is not medically necessary.