

Case Number:	CM15-0026407		
Date Assigned:	02/18/2015	Date of Injury:	09/15/2002
Decision Date:	04/02/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/11/2015

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: Maryland

Certification(s)/Specialty: Internal Medicine, Rheumatology

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 63 year old male, who sustained a work related injury on 9/15/02. The diagnoses have included lumbago, lumbosacral neuritis, lumbosacral spondylosis and depression. Treatments to date have included failed lumbar spine surgery, previous lumbar epidural steroid injection and oral medications. In the PR-2 dated 1/8/15, the injured worker complains of chronic low back pain with pain that radiates down both legs, right greater than right. He rates his pain a 7-8/10. He states his pain is made worse with weight bearing activities and rest helps to relieve it. He has tenderness to palpation mostly at the right sacroiliac joint area. He has extremely limited range of motion in lower back. He states he got seven months, 75% pain relief from previous lumbar epidural steroid injection. On 1/22/15, Utilization Review non-certified requests for Fexofenadine 60mg., #60 with 2 refills, Meloxicam 7.5mg., #60 with 2 refills, Percocet 10/325mg. #60, Savella 50mg., #60 with 2 refills, Soma 350mg., #60 with 2 refills and outpatient right L5-S1 transforaminal lumbar ESI. The California MTUS, Chronic Pain Treatment Guidelines, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fexofenadine 60 mg number sixty (#60) with two (2) refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/allegra.

Decision rationale: This 63 year old male has complained of low back pain since date of injury 9/15/02. He has been treated with lumbar spine surgery, physical therapy, epidural steroid injection and medications to include allegra since at least 09/2013. There is inadequate documentation of the signs and symptoms of allergic rhinitis in this patient as well as inadequate documentation of functional improvement since initiation of therapy with allegra. On the basis of the available medical records and per the guidelines cited above, allegra is not indicated as medically necessary.

Meloxicam 7.5 mg number sixty (#60) with two (2) refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: This 63 year old male has complained of low back pain since date of injury 9/15/02. He has been treated with lumbar spine surgery, physical therapy, epidural steroid injection and medications to include Mobic since at least 09/2013. Per the MTUS guideline cited above, NSAIDS are recommended at the lowest dose for the shortest period in patients with moderate to severe joint pain. This patient has been treated with NSAIDS for at least 15 months duration. There is no documentation in the available medical records discussing the rationale for continued use or necessity of use of an NSAID in this patient. On the basis of this lack of documentation, Mobic is not indicated as medically necessary in this patient.

Percocet 10/325 mg number sixty (#60): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiods, criteria for use Page(s): 76-85, 88-89.

Decision rationale: This 63 year old male has complained of low back pain since date of injury 9/15/02. He has been treated with lumbar spine surgery, physical therapy, epidural steroid injection and medications to include opiods since at least 09/2013. No treating physician reports adequately assess the patient with respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opiods. There is no evidence that the treating physician is prescribing opiods according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opiod

contract and documentation of failure of prior non-opioid therapy. On the basis of this lack of documentation and failure to adhere to the MTUS guidelines, Percocet is not indicated as medically necessary.

Savella 50 mg number sixty (#60) with two (2) refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/savella.

Decision rationale: This 63 year old male has complained of low back pain since date of injury 9/15/02. He has been treated with lumbar spine surgery, physical therapy, epidural steroid injection and medications to include Savella since at least 09/2013. Per the guideline cited above, Savella is recommended for the treatment of fibromyalgia syndrome. There is no documentation in the available medical records of this diagnosis nor is there any medical rationale provided for the use of this medication. On the basis of the available documentation and medical guidelines, Savella is not indicated as medically necessary in this patient.

Soma 350 mg number sixty (#60) with two (2) refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

Decision rationale: This 63 year old male has complained of low back pain since date of injury 9/15/02. He has been treated with lumbar spine surgery, physical therapy, epidural steroid injection and medications to include Soma since at least 09/2013. Per the MTUS guideline cited above, Carisoprodol, a muscle relaxant, is not recommended, and if used, should be used only on a short term basis (4 weeks or less). Use in this patient has exceeded the recommended time frame. On the basis of the MTUS guidelines and available medical documentation, Carisoprodol is not indicated as medically necessary.

outpatient right L5-S1 transforaminal lumbar ESI: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

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

Decision rationale: This 63 year old male has complained of low back pain since date of injury 9/15/02. He has been treated with lumbar spine surgery, physical therapy, epidural steroid

injection and medications. The current request is for right L5-S1 transforaminal lumbar ESI. Per the MTUS guidelines cited above epidural corticosteroid injections are recommended as an option for the treatment of radicular pain when the specific following criteria are met: 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) 3) Injections should be performed using fluoroscopy (live x-ray) for guidance 4) If used for diagnostic purposes; a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The available medical records do not include documentation that criteria (1) above has been met. Specifically, the available provider notes do not document evidence of radiculopathy by physical examination. On the basis of the MTUS guidelines, a lumbar spine epidural corticosteroid injection at L5-S1 is not indicated as medically necessary.