

Case Number:	CM15-0071554		
Date Assigned:	04/21/2015	Date of Injury:	02/27/2014
Decision Date:	05/22/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/14/2015

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: Pennsylvania

Certification(s)/Specialty: Internal 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 45 year old female who sustained an industrial injury on 2/27/2014 when the bench she was sitting on collapsed. The current diagnoses are herniated disc at L5-S1 and bilateral L5 and S1 radiculopathy, bilateral calf tendinitis with sprain/strain, and right ankle sprain/strain. Treatment to date has included medications, electrical muscle stimulation, physical therapy, and aquatic therapy. Notes from physician visits from October 2014 to January 2015 were submitted. Medications in October 2014 included nalfon and Ultram. MRI of the lumbar spine on 4/4/14 showed a 7 mm broad based disc herniation with mild impression on the thecal sac at L5-S1 with mild bilateral neural foraminal stenosis and no definite nerve root compression of the exiting nerve roots. Therapy was noted to have resulted in improved ability to walk and function. Work status in October 2014 was temporarily totally disabled/off work. At a visit on 1/22/15 with secondary treating physician for pain management re-evaluation, the injured worker reported persistent pain in her lower back and right lower extremity rated 7-8/10 in severity on average. Limitations in activities of daily living were noted. She was continuing to perform a home stretching exercise program. Prolonged standing and sitting increase her pain significantly to 10/10. The current medications are Tramadol, Naproxen, and Pantoprazole. Tramadol was noted to cause excessive sedation and Naproxen and tramadol together were noted to cause gastrointestinal (GI) upset. Occasional alcohol use was noted. Examination showed tenderness and guarding in the lumbar paraspinal musculature, decreased range of motion of the lumbar spine, and positive straight leg raise testing on the right. A signed pain contract was discussed. An epidural steroid injection was noted to be scheduled for 2/16/15. At a visit on 1/21/15 with

the primary treating physician, examination showed normal strength and reflexes in bilateral lower extremities with decreased sensation to the right posterior and lateral thigh. Work status was temporarily totally disabled/off work. On 3/20/15, Utilization Review (UR) non-certified requests for daypro 600 mg #60 with 3 refills, tramadol 150 mg #30 with 3 refills, and repeat lumbar epidural steroid injection under fluoroscopic guidance, and modified requests for Topamax 25 mg #30 with 3 refills to #30 without refills, and physical therapy 1 time per week for 6 weeks to the lumbar spine to 1 time per week for 2 weeks. UR cited the MTUS and ODG. The Utilization Review determination discusses a secondary treating physician's progress report dated 2/19/15 indicating that the injured worker had a lumbar epidural steroid injection on 2/16/15 with 20% improvement in pain and improved ability to relax and engage in activity, with continued burning pain in the sides and down the legs.

IMR ISSUES, DECISIONS AND RATIONALES

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

DayPro 600mg with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73.

Decision rationale: This injured worker has chronic back pain. Per the MTUS, nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for treatment of acute exacerbations of chronic back pain. The MTUS does not specifically reference the use of NSAIDs for long term treatment of chronic pain in other specific body parts. NSAIDs are noted to have adverse effects including gastrointestinal side effects and increased cardiovascular risk; besides these well-documented side effects of NSAIDs, NSAIDs have been shown to possibly delay and hamper healing in all the soft tissues including muscles, ligaments, tendons, and cartilage. NSAIDs can increase blood pressure and may cause fluid retention, edema, and congestive heart failure; all NSAIDS are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess. They are recommended at the lowest dose for the shortest possible period in patients with moderate to severe pain. The MTUS does not recommend chronic NSAIDs for low back pain, NSAIDs should be used for the short term only. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. There is no evidence that the prescribing physician is adequately monitoring for toxicity as recommended by the FDA and MTUS. No blood pressure readings or results of laboratory testing were submitted. This injured worker has been prescribed NSAIDS for at least four months, without documentation of functional improvement. Work status remains temporarily totally disabled/off work, there was no documentation of improvement in activities of daily living as a result of NSAID use, and no decrease in medication or decrease in frequency of office visits were noted. Due to length of use not in accordance with the guidelines, lack of functional improvement, and lack of monitoring for toxicity as recommended by the guidelines, the request for daypro is not medically necessary.

Topamax 25mg with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines chronic pain anticonvulsants (antiepilepsy drugs (AEDs)) Page(s): 16-22.

Decision rationale: Per the MTUS, antiepilepsy drugs (AEDs) are recommended for neuropathic pain due to nerve damage. Topamax has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. In this case, there was no documentation of neuropathic pain, and no documentation of failure of other anticonvulsants. Antiepileptic drugs (AEDs) are associated with teratogenicity and should be used with caution in women of childbearing age. There is no evidence that the treating physician has discussed this with this reproductive age female; there was no evidence for informed consent to use a reproductive hazard. Due to lack of documentation of neuropathic pain, lack of documentation of failure of other first-line anticonvulsants, and potential for teratogenicity, the request for topamax is not medically necessary.

Tramadol 150mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: This injured worker has chronic back pain. Tramadol has been prescribed for at least four months. Tramadol is a centrally acting synthetic opioid analgesic which is not recommended as a first line oral analgesic. Multiple side effects have been reported including increased risk of seizure especially in patients taking selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs) and other opioids. It may also produce life-threatening serotonin syndrome. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. No functional goals were discussed, and work status remains temporarily totally disabled/off work. An opioid contract was discussed. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The prescribing physician does not specifically address function with respect to prescribing opioids. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four

domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living and screening for aberrant drug-taking behaviors were not documented. It was noted that tramadol caused excessive sedation and GI upset. As currently prescribed, tramadol does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Physical Therapy 1 time per week for 2 weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: physical medicine treatment.

Decision rationale: Physical medicine is recommended by the MTUS with a focus on active treatment modalities to restore flexibility, strength, endurance, function, and range of motion, and to alleviate discomfort. The ODG states that patients should be formally assessed after a six visit clinical trial to evaluate whether physical therapy has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. Both the MTUS and ODG note that the maximum number of sessions for unspecified myalgia and myositis is 9-10 visits over 8 weeks, and 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. Prior physical therapy was discussed and was noted to have resulted in improved ability to walk and function. Specific improvements in activities of daily living were not discussed. Work status remains temporarily totally disabled/off work. The dates and number of sessions of the prior physical therapy were not provided. The MTUS states that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The injured worker should be able to transition to a home exercise program after the physical therapy already completed. The documentation does note that the injured worker is performing a home exercise program. The records do not contain a sufficient prescription for the currently requested physical therapy, which must contain diagnosis, duration, frequency, and treatment modalities, at a minimum. Reliance on passive care is not recommended. The physical medication prescription is not sufficiently specific, and does not adequately focus on functional improvement. No functional goals were discussed. Additional Physical Medicine is not medically necessary based on the MTUS, lack of sufficient emphasis on functional improvement, and the failure of Physical Medicine to date to result in functional improvement as defined in the MTUS.

Repeat lumbar epidural steroid injection under fluoroscopic guidance: Upheld

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

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

Decision rationale: The MTUS, chronic pain section, page 46 describes the criteria for epidural steroid injections. Epidural injections are a possible option when there is radicular pain caused by a radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There must be documentation of failure of conservative treatment such as exercises, physical methods, nonsteroidal anti-inflammatory agents, and muscle relaxants. An epidural steroid injection must be at a specific side and level. The MTUS recommends that any repeat injection be considered based on the degree of pain relief and functional improvement 6-8 weeks after the initial injection. There are insufficient clinical findings of radiculopathy. One examination was noted to show decreased sensation to the right posterior and lateral thigh, but no motor deficits or loss of reflexes were noted correlating with a specific lesion identified by objective testing. The MRI shows no nerve root compression. No electrodiagnostic testing was submitted. The request does not specify the side and level to be injected as required by the guidelines. The request is for a repeat epidural steroid injection. Records of prior epidural steroid injection were not submitted, although the Utilization Review determination notes an epidural steroid injection on 2/16/15 which did not result in sufficient improvement in pain and function to support a repeat injection. Due to lack of sufficiently specific prescription (no side and level to be injected specified), insufficient findings of radiculopathy, lack of documentation of prior epidural steroid injection, and lack of documentation of required degree of pain improvement and functional improvement after any prior epidural steroid injection, the request for repeat lumbar epidural steroid injection under fluoroscopic guidance is not medically necessary.