

Case Number:	CM15-0097637		
Date Assigned:	05/28/2015	Date of Injury:	02/09/2007
Decision Date:	07/20/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	05/20/2015

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 65 year old female, who sustained an industrial injury on February 9, 2007, incurring low back and right knee injuries after a fall. She was diagnosed with lumbar facet arthropathy, lumbar radiculitis, lumbar strain, lumbar stenosis and lumbar degenerative disc disease. She underwent a lumbar spinal fusion on October 12, 2011, and surgical hardware removal on March 26, 2013 and a right total knee replacement in March 2015. Treatment included pain medications, anti-anxiety drugs, proton pump inhibitor, topical analgesic creams physical therapy for the knee, chiropractic sessions and acupuncture. Electromyography studies were abnormal and computed tomography of the spine revealed degenerative disc disease, canal stenosis and lumbar foraminal narrowing. Currently, the injured worker complained of low back pain and bilateral leg pain. The treatment plan that was requested for authorization included bilateral lumbar epidural steroid injection, prescriptions for Ketoprofen cream, Prilosec, Zanaflex, Norco, a retroactive urine drug screen and continued follow-ups for treatment of depression.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral TFESI at L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI.

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

Decision rationale: A selective nerve root block, or transforaminal epidural steroid injection (ESI), is a variation of the traditional midline ESI; the spinal nerve roots exit the spine laterally. Based on a patient's medical history, a physical exam, and MRI findings, often a specific inflamed nerve root can be identified. According to the CA MTUS guidelines, criteria for ESI's include the following: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing; initially unresponsive to conservative treatment; and no more than two nerve root levels should be injected using transforaminal blocks. Repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. In this case, there is no documentation of the benefit from previous injection therapy in terms of reduction in the use of pain medication and increased functional benefit. Medical necessity for the requested injection has not been established. The requested injection is not medically necessary.

CM-3-Ketoprofen cream 20%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. The requested topical analgesic contains Ketoprofen 20%. Ketoprofen is not currently FDA approved for a topical application, and has an extremely high incidence of photo-contact dermatitis. Medical necessity for the requested topical medication has not been established. The requested topical cream is not medically necessary.

Prilosec 20 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation indicating the patient has any GI symptoms or GI risk factors. This patient is not currently taking an NSAID. Based on the available information provided for review, the medical necessity for Prilosec has not been established. The requested medication is not medically necessary.

Zanaflex 4 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 66.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and considered an adjunct treatment for fibromyalgia. According to the CA MTUS Guidelines, muscle relaxants have not been considered any more effective than non-steroidal anti-inflammatory drugs (NSAIDs) for pain or overall improvement. There is no additional benefit shown in combination with NSAIDs. In addition, sedation is the most commonly reported adverse effect of muscle relaxant medications. In this case, the patient has no reported lumbar spasm on physical exam. In addition, there is no documentation of functional improvement with use of this medication. Also, the guideline criteria do not support the long-term (>2 wks) use of muscle relaxants. Medical necessity for the requested medication has not been established. The requested medication, Zanaflex, is not medically necessary.

Norco 5/325 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 5/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately 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 no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Continued follow ups for treatment of depression: Overturned

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 ACOEM Guidelines, Chapter 7, page 127.

Decision rationale: According to the CA MTUS/ACOEM guidelines, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is specific rationale identifying the medical necessity of the requested follow-up for treatment of the patient's depression. Medical necessity for the requested service has been established. The requested service is medically necessary.

Retro urine drug screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Screen Page(s): 43.

Decision rationale: According to CA MTUS (2009), a urine drug screen is recommended as an option to assess for the use or the presence of illegal drugs. According to ODG, urine drug testing (UDT) is a recommended tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. In this case, the patient's opiate therapy had previously been denied. There was no indication for a urine drug screen. Medical necessity for the requested test was not established. The requested urine drug screen is not medically necessary.