

Case Number:	CM13-0035152		
Date Assigned:	12/13/2013	Date of Injury:	01/15/1998
Decision Date:	02/21/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	10/16/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

A 42-year-old male with date of injury of 01/15/1998. Report by [REDACTED], 07/23/2013, listed diagnoses of mild to moderate foraminal stenosis, facet arthropathy and 3-mm disk protrusion at multiple levels, status post dorsal column stimulator with lead placement 2006, removal of the dorsal stimulator in 2008. Presenting symptoms are continued low back pain, constant, slight to intermittent moderate occasionally severe radiation into the right thigh and to the foot with numbness and tingling, has difficulty with standing, walking, sleeping. MRI was recently obtained that showed cage placement at L5-S1 with 3-mm disk protrusions from L1 to L5, facet synovitis at L3-L4, minimal retrolisthesis at L3-L4. Recommendations were for CT myelogram in lumbar spine to evaluate for further stenosis primarily at L4-L5 and L5-S1, EMG studies. The patient was dispensed medications. The patient remained Temporarily Totally Disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computed tomography (CT) myelogram of lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), CT-Myelogram.

Decision rationale: The Physician Reviewer's decision rationale: This patient has had multiple lumbar surgeries including fusion at L5-S1, foraminotomy, laminectomies, and hardware removal. The patient has had spinal cord stimulation in 2006 which was then removed in 2008. The patient recently had MRI of the lumbar spine that showed fusion at L5-S1 with multilevel disk protrusions at L2 to L5. The treating physician has asked for a CT myelogram. He would like to obtain a CT myelogram to get a better look at the nerve roots and the spinal stenosis. The patient has ongoing poorly controlled low back pain at an intensity of 7/10 with radiation down the lower extremity. MTUS and ACOEM Guidelines do not provide discussion for CT myelogram. ODG Guidelines states that it is not recommended except for indications for CT scan and that CT myelography is okay if MRI is unavailable or contraindicated or inconclusive. CT myelogram may be indicated for surgical planning especially in regard to the nerve roots. In this case, MRI of the lumbar spine adequately demonstrated the condition in the nerve roots. CT myelogram is indicated when MRI cannot be performed which is not the case in this patient. Recommendation is for denial.

. **Norco 10/325mg, #60:** Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines on Long-term Opioid use Page(s): 88-89.

Decision rationale: The Physician Reviewer's decision rationale: Despite review of medical reports from 02/19/2013 to 09/24/2013, there is not a single mention of how the patient is doing with the opiates. There are no pain evaluations before and after medication, there are no numerical scales describing the patient's function. There are no discussions of adverse behavior or adverse effects, analgesia, and activities of daily living. MTUS Guidelines, page 60, clearly requires pain assessment and function with the use of these medications. For ongoing use of opiates, functional improvement compared to baseline, functioning measurement at a 6-month interval is required. Under outcome measures, MTUS also requires documentation of current pain. The least pain reported over the periods since last assessment, average pain, and intensive pain after taking the opiates, et cetera. In this case, none of this information is provided. Recommendation is for denial.

Ambien 10mg, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter.

Decision rationale: The Physician Reviewer's decision rationale: Review of the reports show that this patient has been on Ambien on a chronic basis. MTUS Guidelines do not recommend use of Ambien on a long-term basis. If it is used, only short-term use is recommended. Given that this patient has been provided with Ambien on a long-term basis, recommendation is for denial.

. **Protonix 20mg, #60:** Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: The Physician Reviewer's decision rationale: This patient is prescribed Protonix. However, review of the reports from 02/19/2013 to 09/24/2013 do not discuss any GI assessment. MTUS Guidelines, page 9, requires determination of risk for GI event for patients that are taking NSAIDs. The documentations required are age greater than 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of aspirin, corticosteroids, and/or anticoagulants, et cetera. In this patient, none of this information is provided. Recommendation is for denial.

Deltasone: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The Physician Reviewer's decision rationale: This patient is prescribed Deltasone which is oral prednisone. The patient suffers from chronic low back pain with history of multiple lumbar surgeries including fusion at L5-S1. Oral corticosteroids are not discussed in MTUS or ACOEM Guidelines. However, ODG Guidelines have a detailed discussion regarding oral corticosteroids. This is recommended in limited circumstances for acute radicular pain. This patient has had chronic radicular symptoms with history of multiple surgeries in the lumbar spine. The treating physician has been prescribing this medication on a chronic basis. Recommendation is for denial.

Terocin cream 120ml with 2 tubes: Upheld

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

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

Decision rationale: The Physician Reviewer's decision rationale: This patient suffers from chronic low back pain with history of multiple surgeries to lumbar spine. The treating physician has prescribed Terocin cream which contains 4% lidocaine. MTUS Guidelines, page 112, recommends use of lidocaine for neuropathic pain or for localized peripheral pain. Furthermore, topical lidocaine is not recommended in creams, lotions, or gels, being only recommended as a dermal patch (Lidoderm). Given that Terocin is either a cream or lotion, recommendation is for denial.

Lidoderm patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The Physician Reviewer's decision rationale: This patient presents with chronic low back pain with multiple surgeries in the past including lumbar fusion at L5-S1. The patient has significant radicular symptoms with the MRI demonstrating spinal stenosis and multilevel disk protrusions. The treating physician has been prescribing Lidoderm patches. Recommendation is for authorization. MTUS Guidelines, page 112, recommends the use of Lidoderm patches from neuropathic pain or for localized peripheral pain. This patient suffers from neuropathic pain due to radicular symptoms of the lumbar spine. Recommendation is for authorization.