

Case Number:	CM13-0035987		
Date Assigned:	12/13/2013	Date of Injury:	12/12/2003
Decision Date:	08/20/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/18/2013

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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/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:

The injured worker is a 59-year-old female who reported an injury on 12/12/2003 due to unknown mechanism. The injured worker complained of constant back pain. On physical examination dated 12/20/2013, lumbar spine examination revealed motor strength was at 5/5 bilaterally in the lower extremities, sensory was diminished along the right L5-S1, bilateral knees and ankles 2+, straight leg raise positive on the right for radicular signs and symptoms until at 60 degrees. The injured worker's diagnoses were cervical disc with radiculitis, degeneration of the cervical disc, lumbar disc with radiculitis, degeneration of the lumbar disc, and knee pain. The injured worker's medications were Amlodipine, Ketoprofen, Tizanidine, Norco 10/325 mg, Lisinopril, Ambien, Gabapentin, Atenolol, Omeprazole, vitamin D, and aspirin 81 mg. Past surgical history includes esophageal dilatation, breast augmentation in 1982, implant removal in 1992, and bilateral knee replacements in 04/2005. The injured worker's prior treatment or diagnostics included chiropractic services, physical therapy, epidural injections at L5, S1, on 11/16/2009 with 50% relief, L5, S1 on 7/13/2012 with 50% relief and medication counseling. Per the request for authorization form dated 09/23/2013, rationale for the x-ray of the lateral lumbar and a psychological evaluation to determine if the injured worker is a candidate for a spinal cord stimulator trial.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 2mg#60: Upheld

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

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

Decision rationale: The request for Tizanidine 2 mg #60 is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for the short-term treatment of acute exacerbation in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most low back pain cases there is no benefit beyond NSAIDs in pain and overall improvement. The injured worker has been taking this medication since at least 09/2013. The efficacy of the medication was not addressed and the recommended duration of use has been exceeded. Furthermore, there was no proposed frequency mentioned on the request. As such, the request for Tizanidine 2 mg #60 is not medically necessary.

One time psych evaluation for possible spinal cord stimulator (SCS) trial: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator Page(s): 105.

Decision rationale: The request for 1 time psych evaluation for possible spinal cord stimulator trial is not medically necessary. The injured worker had a history of cervical and lumbar radiculopathy, bilateral upper and lower radiculitis in the lower extremities, and knee pain. According to the California Medical Treatment Utilization Schedule, spinal cord stimulators are recommended only for selected patients in cases where less invasive procedures have failed or are contraindicated for specific condition indicated and following a successful temporary trial. Although there is limited evidence in favor of spinal cord stimulators for failed back syndrome and complex regional pain syndrome, trials are needed to confirm whether spinal cord stimulator is an effective treatment for certain types of chronic pain. There is no supporting documentation in favor of the injured worker having failed back syndrome or complex regional pain syndrome. According to guidelines, a psychological evaluation is needed for a spinal cord stimulator trial and is recommended. However, in the absence of documentation on the injured worker meeting indications for a spinal cord stimulator, the request for 1 time psychological evaluation for possible spinal cord stimulator is not medically necessary.

Anteroposterior (AP) / lateral lumber x-ray: 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), Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 303-305.

Decision rationale: An Anteroposterior lateral lumbar x-ray is not medically necessary. According to the California Medical Treatment Utilization Review Schedule, lumbar spine x-ray is not recommend in patients with low back pain in the absence of red flags or serious spinal pathology even the pain has persisted for at least 6 months. However, it may be appropriate when the physician believes it would aid in patient management. X-ray being requested to assess whether the injured worker is a candidate for possible spinal cord stimulator. According to the documentation submitted for review, the requested x-rays are to be performed prior to the spinal cord stimulator to determine if the injured worker would be a candidate. As the spinal cord stimulator trial is not supported, the associated x-rays would not be supported. As such, the proposed request for Anteroposterior lateral lumbar x-ray is not medically necessary.