

<b>Case Number:</b>	CM13-0040944		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	07/31/2001
<b>Decision Date:</b>	03/11/2014	<b>UR Denial Date:</b>	10/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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 and Rehabilitation and is licensed to practice in Texas and Oklahoma. 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:

The patient is a 51-year-old male who reported an injury on 07/31/2001. The patient was reportedly injured when he was moving heavy equipment with coworkers in a fitness room. While moving a piece of equipment weighing 500 pounds, the patient felt a pop in his low back followed by pain radiating into his left leg. The patient subsequently underwent a laminectomy and discectomy at the L4-5 level on 11/06/2001. Postoperatively, the patient continued to have left leg pain whereupon an MRI was performed on 01/07/2002, which revealed disc protrusion with disc disease at L3-4, L4-5, and L5-S1 as well as scar tissue at the surgical site. The patient underwent a series of lumbar epidural steroid injections, which did provide some benefit; however, physical therapy was denied and subsequent gains from his epidural steroid injections were eventually lost. He was declared permanent and stationary on 09/20/2002 and was placed on permanent work restriction limiting him to semi-sedentary work as well as a provision for future medical care including additional surgery. The patient continued to be seen from at least 04/2013 through 10/21/2013. On his most recent follow-up consultation, the patient was noted to have significant low back pain that radiates into his extremities. On the physical examination, muscle guarding was present on the left side and the patient was noted to ambulate with an antalgic gait. There was numbness that existed involving the lateral aspect of the left lower extremity and the plantar surface of the left foot. Straight leg test was markedly positive on the left side at approximately 10 degrees. The patient has been diagnosed with a history of lumbar radiculopathy, status post lumbar laminectomy, and postsurgical persistent lumbar radiculopathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Protonix 20mg #60, one (1) twice a day: 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, GI symptoms & cardiovascular risk Page(s): 68.

**Decision rationale:** The Chronic Pain Guidelines indicate that patients at intermediate risk for gastrointestinal events and no cardiovascular disease may benefit from the use of a proton pump inhibitor. In the case of this patient, he has been utilizing several different oral medications to help relieve his back pain. The order for Protonix would be considered appropriate if the other medications were causing him any sort of gastric upset. However, the guidelines do not support the use of this medication for prophylactic reasons. Without having a sufficient rationale for prescribing Protonix, the medical necessity for its use cannot be established. As such, the requested service is non-certified.

**Lortab 7.5/500mg #30, one (1) every evening: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: Short Acting Opioids..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids Page(s): 74-96.

**Decision rationale:** The Chronic Pain Guidelines indicate that opioid tolerance develops with the repeated use of opioids and brings about the need to increase the dose and may lead to sensitization. It is now clear that analgesia may not occur with open-ended escalation of opioids. It has also become apparent that analgesia is not always sustained over time, and that pain may be improved with the weaning of opioids. In the case of this patient, he has been utilizing Lortab since at least 06/2013. There are no quantitative measurements provided in the documentation indicating that this medication has been effective in reducing the patient's pain or increasing his functional ability. Therefore, it is recommended that the medication be tapered off in order to avoid tolerance and addiction, without having a positive effect from the use of this medication. At this time, without having sufficient documentation indicating the efficacy of this medication, the requested service cannot be warranted and is non-certified.

**Flexeril 7.5 mg #90, one (1) three times a day: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: Muscle relaxants (for p.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine (Flexeril®) Page(s): 41-42.

**Decision rationale:** The Chronic Pain Guidelines indicate that cyclobenzaprine is recommended as an option, using a short course of therapy. It is more effective than placebo in the management of back pain; the effect is modest and comes with a price of greater adverse effects. The effect is greatest in the first four (4) days of treatment, suggesting that shorter courses may be better. The treatment should be brief. In the case of this patient, he has been utilizing Flexeril since at least 05/2013. The documentation does not provide quantitative measurements indicating that this medication has been effective in reducing the patient's discomfort to include muscle spasms, nor has it been noted to increase his functional improvement. Therefore, without having sufficient information pertaining to the efficacy of this medication, the continuation of its use cannot be established. The recommendation is for tapering from the Flexeril in order to prevent sensitization and potential addictive behaviors towards the use of this medication. However, without having objective measurements pertaining to the efficacy of this medication, the requested service cannot be warranted and is non-certified.

**Muscle stim unit (replacement):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

**Decision rationale:** The Chronic Pain Guidelines indicate that neuromuscular electrical stimulation (NMES) devices are not recommended. NMES is used primarily as part of a rehabilitation program following a stroke and there is no evidence to support its use in chronic pain. The documentation does not indicate that the last time the patient utilized a neuromuscular stimulation device for pain relief. Furthermore, there is no quantitative measurement indicating that this mechanism of treatment has been effective in reducing the patient's pain and increase in functional ability. Without having sufficient documentation providing previous use of a muscle stimulating device, the requested service cannot be warranted and is non certified.

**Re-evaluation with spine specialist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 288, 305-306.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Part 1 Page(s): 1.

**Decision rationale:** The Chronic Pain Guidelines indicate that if the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. In the case of this patient, the documentation notes that he has had ongoing complaints of chronic back pain, which has been unrelieved with his usual methods of care to include oral medications and the reported use of a neuromuscular stimulator. The most recent documentation did not include red flag issues to be noted in the patient's condition. Therefore, the rationale for a re-evaluation with a spine specialist cannot be established. As such, the requested service is non-certified.

