

<b>Case Number:</b>	CM13-0045354		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	03/08/2012
<b>Decision Date:</b>	03/20/2014	<b>UR Denial Date:</b>	10/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2013

### 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, and is licensed to practice in Texas. 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 36-year-old male who reported an injury on 03/08/2012. The patient was reportedly shoveling trash off of a truck when he felt a pop and sudden pain to the lower back. The patient is diagnosed with L4-5 and L5-S1 protrusion with radiculopathy, disproportionate neurologic findings in the bilateral lower extremities, and rule out lumbar intradiscal component. The patient was recently seen by [REDACTED] on 12/10/2013. The patient reported ongoing lower back pain with right lower extremity symptoms, rated 8/10. Physical examination revealed tenderness to the lumbar spine, limited lumbar range of motion, positive straight leg raise on the right, and lumbar paraspinal musculature spasm. Treatment recommendations included physical therapy for the lumbar spine 3 times per week for 4 weeks, as well as continuation of current medication including Tramadol ER, Hydrocodone, Naproxen, Pantoprazole, and Cyclobenzaprine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Request for LSO:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation In. Harris J (Ed), Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 300.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As per the documentation submitted, the patient's physical examination only revealed tenderness to palpation with limited lumbar range of motion. There was no documentation of significant instability. The medical necessity for the requested DME has not been established. Therefore, the request is non-certified.

**Request for Cyclobenzaprine 7.5mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report 8/10 lower back pain with right lower extremity symptoms. The patient's physical examination continues to reveal palpable muscle spasm. Based on the clinical information received and California MTUS Guidelines, the request is non-certified.

**Request for Pantoprazole 20mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.

**Request for Naproxen Sodium 550mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report 8/10 lower back pain with right lower extremity symptoms. Documentation of a significant functional improvement in the patient's physical examination was not provided. Additionally, California MTUS Guidelines state there is no evidence of long-term effectiveness for pain or function. Based on the clinical information received and California MTUS Guidelines, the request is non-certified.

**Request for Tramadol ER 150mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report 8/10 lower back pain with right lower extremity symptoms. There is no documentation of a significant change in the patient's physical examination that would indicate functional improvement. Based on the clinical information received and California MTUS Guidelines, the request is non-certified.

**Request for 12 physical therapy sessions for the lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009), Physical Medicine Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for fading of treatment frequency, plus active, self-directed home physical medicine. As per the documentation submitted, the patient has previously participated in a course of physical therapy. However, documentation of objective, measurable improvement was not provided. It is noted that the patient has only received temporary relief with prior physical therapy treatment. Without documentation of objective measurable improvement, the current request for additional

physical therapy cannot be determined as medically appropriate. Additionally, the current request for 12 sessions of physical therapy exceeds guideline recommendations. Based on the clinical information received and California MTUS Guidelines, the request is non-certified.