

<b>Case Number:</b>	CM13-0049923		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	08/15/2003
<b>Decision Date:</b>	03/25/2014	<b>UR Denial Date:</b>	10/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/08/2013

### 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 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 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 43-year-old who reported an injury on 08/15/2003. The mechanism of injury involved a motor vehicle accident. The patient is currently diagnosed with chronic postoperative pain, chronic pain syndrome, lumbar post-laminectomy syndrome, lumbar radiculitis, degeneration of the intervertebral disc, lumbago, sciatica, closed dorsal fracture, cervical post-laminectomy syndrome, cervicalgia, and osteoporosis. The patient was seen by [REDACTED] on 10/03/2013. The patient reported numbness, tingling, and weakness in the left lower extremity as well as the left cervical spine and shoulders. Physical examination revealed diminished lumbar and cervical range of motion with 5/5 strength in bilateral upper and lower extremities. The patient also demonstrated tenderness to palpation throughout the thoracic and lumbar paraspinal muscles as well as bilateral sciatic notches. Treatment recommendations included continuation of current medications, a home exercise program, approval to start a gym membership, cervical medial branch blocks, cervical epidural steroid injections, testosterone levels, a CBC, a CMP, and an internal medicine consultation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Duragesic 150 mcg, 15 count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44 and 74-82.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state Duragesic is not recommended as a first line therapy. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Documentation of objective measurable improvement has not been provided. The patient continues to report persistent pain. Satisfactory response to treatment has not been indicated. The request for Duragesic 150 mcg, 15 count, is not medically necessary or appropriate.

**Norco 10/325 mg, 90 count:** Upheld

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

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

**Decision rationale:** The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment 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 constant pain in the neck and lower back. Satisfactory response to treatment has not been indicated. The request for Norco 10/325 mg, 90 count, is not medically necessary or appropriate.

**Zanaflex 4 mg, 150 count:** Upheld

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

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

**Decision rationale:** The Chronic Pain Medical Treatment 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. Efficacy appears to diminish over time and prolonged use may lead to dependence. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report constant pain in the neck and lower back. There is no documentation of palpable muscle spasm, spasticity, or muscle tension upon physical examination. . The request for Zanaflex 4 mg, 150 count, is not medically necessary or appropriate.

**Celebrex 200 mg, 30 count:** Upheld

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

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state NSAIDs (non-steroidal anti-inflammatory drugs) 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 constant neck and lower back pain. There is no documentation of a satisfactory response to treatment. The Chronic Pain Medical Treatment Guidelines state there is no evidence of long-term effectiveness for pain or function. The request for Celebrex 200 mg, 30 count, is not medically necessary or appropriate.

**Omeprazole 20 mg, 30 count:** Upheld

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

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

**Decision rationale:** The Chronic Pain Medical Treatment 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 (non-steroidal anti-inflammatory drugs). 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. The request for Omeprazole 20 mg, 30 count, is not medically necessary or appropriate.

**One gym membership:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter - Lumbar and 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) Knee & Leg Chapter, Gym Memberships

**Decision rationale:** The Official Disability Guidelines state gym memberships are not recommended as a medical prescription unless a home exercise program has not been effective and there is a need for equipment. As per the documentation submitted, there is no evidence of a failure to respond to a home exercise program. There is also no indication of the need for

specialized equipment. The request for one gym membership is not medically necessary or appropriate.

**One left cervical C5-6 intralaminar epidural steroid injection with fluoroscopic guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174 and 181.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehab efforts. There is no evidence of radiculopathy upon physical examination. There are no imaging studies or electrodiagnostic reports submitted for review. There is also no indication of a failure to respond to recent conservative treatment including exercises and physical methods. The patient does not currently meet criteria for the requested procedure. The request for one left cervical C5-6 intralaminar epidural steroid injection with fluoroscopic guidance is not medically necessary or appropriate.

**One laboratory service for testosterone, complete blood count, and complete metabolic panel:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute and Chronic) Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70 and 111.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recognize the risk for liver and kidney problems secondary to long-term use and high dose use of NSAIDs (non-steroidal anti-inflammatory drugs) and acetaminophen. There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy. The frequency of performing laboratory evaluation testing is based on patient risk factors and related symptoms. Studies have evaluated the use of testosterone replacement in patients with opioid induced androgen deficiency, measuring morning serum free testosterone levels and PSA (prostate-specific antigen) prior to replacement. As per the documentation submitted, the patient does not exhibit signs or symptoms to suggest an abnormality due to medication use. The request for one laboratory service for testosterone, complete blood count, and complete metabolic panel is not medically necessary or appropriate.