

Case Number:	CM13-0058283		
Date Assigned:	12/30/2013	Date of Injury:	08/25/2010
Decision Date:	05/02/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	11/26/2013

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 and Pain Management 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 60-year-old male who reported an injury on 08/25/2010. The mechanism of injury was not stated. The injured worker is currently diagnosed with lumbar radiculopathy, postlaminectomy syndrome, and lumbar spondylosis without myelopathy. The injured worker was evaluated on 11/09/2013. The injured worker reported persistent lower back pain with radiation to bilateral lower extremities. The injured worker also reported stabbing, burning, numbness, aching, and constant pain. The injured worker reported 6/10 pain with medication. Physical examination revealed severe pain with range of motion, positive straight leg raising, and a slowed ambulation. Treatment recommendations included continuation of current medication and a replacement LSO back brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF NEW LUMBOSACRAL ORTHOTIC (LSO) BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 300..

Decision rationale: The 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 injured worker currently utilizes an LSO brace. There is no documentation of significant instability upon physical examination. The injured worker is no longer within the acute phase of treatment. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request is non-certified.

PHARMACY PURCHASE OF PERCOCET 10/325MG, #90: Upheld

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

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

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the injured worker has utilized Percocet 10/325 mg since 12/2012. Despite ongoing use of this medication, the injured worker continues to report persistent lower back pain with radiation to bilateral lower extremities. There is no change in the injured worker's physical examination that would indicate functional improvement. Based on the clinical information, the request is non-certified.

Amitriptyline 150mg # 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: The California MTUS Guidelines state antidepressants are recommended as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. Amitriptyline is indicated for neuropathic pain. As per the documentation submitted, the injured worker has utilized amitriptyline 150 mg since 07/2013. Despite ongoing use, the injured worker continues to report persistent lower back pain with radiation, stabbing, burning, numbness, and aching in bilateral lower extremities. Satisfactory response to treatment has not been indicated. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.

CELEBREX 200MG # 60: 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).

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

Decision rationale: The California MTUS Guidelines state Celebrex is indicated for the relief of signs and symptoms of osteoarthritis, rheumatoid arthritis, and ankylosing spondylitis. The injured worker does not maintain any of the abovementioned diagnoses. Additionally, the injured worker has utilized Celebrex 200 mg since 10/2012. There is no documentation of objective functional improvement. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.