

Case Number:	CM13-0059210		
Date Assigned:	12/30/2013	Date of Injury:	06/05/2008
Decision Date:	03/27/2014	UR Denial Date:	11/04/2013
Priority:	Standard	Application Received:	12/02/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 41 year-old male with a date of injury of 06/05/2008. The listed diagnoses per [REDACTED] dated 09/10/2013 are: 1) Status post spinal fusion and transforminal lumbar interbody fusion, January 2012 2) Persistent right lumbar radiculopathy involving the right L5 and S1 nerve roots. According to report dated 09/10/2013 by [REDACTED], the patient presents with low back pain that radiates down into his right lower extremity. The pain in his right lower extremity is more severe than his low back pain. The pain is noted as "burning, chronic pain, associated with muscle spasms." Examination of the low back shows tenderness to palpation over the lumbar spinous muscles. Facet loading is positive on the right. There is limited range of motion in forward flexion and extension of the lumbar spine. Decreased sensation L4, L5 and S1 dermatomes on the right.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Prilosec 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Omeprazole (Prilosec).

Decision rationale: This patient presents with low back pain that radiates down into his right lower extremity. The treater requests Prilosec 20mg #60. The MTUS guidelines states Omeprazole is recommended with precautions as indicated below. Clinicians should weigh the indications for Non-Steroidal Anti-Inflammatory Drugs (NSAID)'S against both GI and cardiovascular risk factors. Determining if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). In this case, the treater does not provide any GI risk assessment. There is no mention of gastric irritation or pain, no peptic ulcer history, no concurrent use of ASA, anti-coagulation, etc. In addition, the patient is not noted to be taking any NSAIDs. The Prilosec is not medically necessary and recommendation is for denial.

1 Prescription of Zanaflex 4mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS Page(s): 66.

Decision rationale: This patient presents with low back pain that radiates down into his right lower extremity. The treater requests Zanaflex. For ANTISPASTICITY/ANTISPASMODIC DRUGS, the MTUS guidelines pg 66 states, "Tizanidine (Zanaflex[®], generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain." MTUS pg 66 allow for the use of Zanaflex for low back pain, myofascial pain and fibromyalgia. Given this patient's chronic low back pain, recommendation is for authorization.

1 Prescription of Hydrocodone/apap 10/325 mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines chronic opiates Page(s): 88-89.

Decision rationale: This patient presents with low back pain that radiates down into his right lower extremity. The treater requests Hydrocodone #180. Utilization review dated 11/04/2013 modified certification from #180 to #45 for weaning purposes. UR also noted that treater was notified to starting weaning patient from Norco in prior review dated 08/08/2013. For chronic opiates use MTUS guidelines (MTUS pgs 88, 89) require functioning documentation using a numerical scale or a validated instrument at least once every 6 months. Documentation of the four A's (Analgesia, ADL's, Adverse side-effects, Adverse behavior) are required. Furthermore, under outcome measures, it also recommends documentation of current pain; average pain; least pain; time it takes for medication to work; duration of pain relief with medications, etc. The

treater states in report dated 09/10/2013 "Norco and Cymbalta help his pain." There are no numerical scale measuring pain and no discussions regarding any functional improvements. A mere statement that the opioids "help his pain" is not sufficient to warrant chronic opioid use. Recommendation is for denial.

1 Spinal Cord Stimulator Trial x2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulation Page(s): 105-107.

Decision rationale: This patient presents with low back pain that radiates down into his right lower extremity. The treater requests 1 spinal cord stimulator. Utilization review dated 11/04/2013 denied request stating lack of information on why 2 stimulators are being requesting. Under Spinal Cord Stimulation MTUS guidelines, pgs 105-107 states "Recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions, and following a successful temporary trial." ODG guidelines regarding spinal cord stimulators also states for "failed back syndrome (persistent pain in patients who have undergone at least one previous back operation and are not candidates for repeat surgery), when all of the following are present: (1) symptoms are primarily lower extremity radicular pain; there has been limited response to non-interventional care (e.g. neuroleptic agents, analgesics, injections, physical therapy, etc.); (2) psychological clearance indicates realistic expectations and clearance for the procedure; (3) there is no current evidence of substance abuse issues; (4) there are no contraindications to a trial; (5) Permanent placement requires evidence of 50% pain relief and medication reduction or functional improvement after temporary trial." In this case, the patient has not had a psychological clearance. In fact, the patient was seen for a psyche test on 06/28/2013 in which the report seems to raise some concerns stating "the claimant has a pain disorder with psychological feature and a medical condition and that there are likely psychological factors which negatively impact on the magnitude of the claimants' subjective pain complaints." ODG recommends a psychological clearance indicating realistic expectations and clearance for the procedure. Recommendation is for denial.