MAXIMUS Federal Services

Case Number:	CM14-0173832		
Date Assigned:	10/27/2014	Date of Injury:	03/15/2001
Decision Date:	12/05/2014	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	10/21/2014

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 64-year-old male with date of injury of 03/15/2001. The listed diagnoses per [redacted] from 09/03/2014 are:1. Status post lumbar fusion, grade 1 retrolisthesis, L3-L4.2. Thoracic degenerative disk disease, strain.3. Multiple medical problems including chronic use of oxygen.4. Previous tracheotomy.5. Status post placement of inferior vena cava filter.6. Chronic iliac crest donor pain. According to this report, the patient complains of severe back pain with bad episodes of low back pain. He states that he goes to sleep, wakes up, and cannot move. The patient pain is up to 10/10 in severity. He also complains of right leg pain that is severe. The patient states that with medications, his pain has improved and is more functional of at least 50% less pain. The examination of the lumbar spine shows straight leg raise is positive on the left at 45 degrees. Positive Lasgue's. Paraspinal muscle spasm is noted. Decreased motor strength in the left lower extremity at 3/5, L5-S1 distribution. Positive antalgic gait. There is less leg pain in the left. Straight leg raise is mildly positive on the right. The documents include a lumbar epidural operative report from 08/04/2014 and progress reports from 04/29/2014 to 09/03/2014. The utilization reviewer denied the request on 10/06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fiorcet 325/50/40mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate containing analgesics Page(s): 23.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) under the Pain Chapter on barbiturate-containing analgesic agents (BCAs)

Decision rationale: This patient presents with low back and leg pain. The treater is requesting FIORICET 325/50/40 MG #90. The MTUS and ACOEM Guidelines do not address this request. However, ODG Guidelines under the Pain Chapter on barbiturate-containing analgesic agents (BCAs) states, "Not recommended for chronic pain. The potential for drug dependence is high, no evidence exist to show clinically important enhancement of analgesic efficacy of BCAs due to barbiturate constituents. There is risk of medication abuse as well as rebound headache." The records do not show a history of Fioricet use. In this case, ODG Guidelines do not recommend Fioricet for treatment of chronic pain. This request is not medically necessary.

Flexeril 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine Page(s): 64.

Decision rationale: This patient presents with low back and leg pain. The treater is requesting FLEXERIL 10 MG #60. The MTUS Guidelines page 64 on cyclobenzaprine states that it is recommended as a short course of therapy with limited mixed evidence not allowing for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and central nervous system depressant with similar effects to tricyclic antidepressants (amitriptyline). This medication is not recommended to be used for longer than 2 to 3 weeks. The records do not show a history of Flexeril use. While a trial of Flexeril is reasonable, the requested quantity exceeds MTUS recommended 2- to 3-week treatment. This request is not medically necessary.

LSO brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) under Low back chapter on lumbar supports

Decision rationale: This patient presents with low back and leg pain. The treater is requesting an LSO BRACE. The ACOEM Guidelines page 301 on lumbar bracing states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines regarding lumbar supports states, "Not recommended for prevention;

however, recommended as an option for compression fracture and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain, very low-quality evidence, but maybe a conservative option." The 04/29/2014 report notes that the treater is requesting a custom LSO brace due to "anterior abdominal deformities." In this case, while the patient presents with low back pain, ODG states that there is very low-quality evidence to support the use of lumbar supports for the treatment of chronic low back pain. This request is not medically necessary.

Prilosec 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medication and gastrointestinal symptoms Page(s).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID, GI symptoms, and cardiovascular risk Page(s): 68-69.

Decision rationale: This patient presents with low back and leg pain. The treater is requesting an LSO BRACE. The ACOEM Guidelines page 301 on lumbar bracing states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines regarding lumbar supports states, "Not recommended for prevention; however, recommended as an option for compression fracture and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain, very low-quality evidence, but maybe a conservative option." The 04/29/2014 report notes that the treater is requesting a custom LSO brace due to "anterior abdominal deformities." In this case, while the patient presents with low back pain, ODG states that there is very low-quality evidence to support the use of lumbar supports for the treatment of chronic low back pain. This request is not medically necessary.

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation) Page(s): 114-11.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

Decision rationale: This patient presents with low back and leg pain. The treater is requesting a TENS UNIT. The MTUS Guidelines pages 114 to 116 on TENS unit states that it is not recommended as a primary treatment modality, but a 1-month, home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. The records do not show a history of TENS unit use. Despite the review of records from 04/29/2014 to 09/03/2014, there is no documentation of the patient's use of the TENS unit and how often it was used. It does not appear that the patient has trialed a TENS unit. In this case, MTUS Guidelines recommends a 1-month, home-based TENS trial to determine its efficacy in terms of pain relief and function. This request is not medically necessary.