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| Case Number: | CM14-0066608 | | |
| Date Assigned: | 07/11/2014 | Date of Injury: | 03/13/2003 |
| Decision Date: | 09/10/2014 | UR Denial Date: | 04/23/2014 |
| Priority: | Standard | Application Received: | 05/09/2014 |

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 Pain Management 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:

This is a male patient with a date of injury of March 13, 2003. A utilization review determination dated April 23, 2014 recommends non-certification of one cold therapy unit, Soma 350 mg #60, and a three view x-ray of the lumbar spine. A progress note dated March 28, 2014 identifies subjective complaints of continued lower back pain with radiation into bilateral lower extremities left greater than right. The patient has back pain that is present 100% of the time, he has numbness and tingling in bilateral lower extremities left greater than right, and his pain level most days in the lumbar spine and left leg is a level 8-9 on a 10 scale. On a good day his pain level is an 8 and on a bad day his pain increases to a 10. Coughing and sneezing aggravate his lower back, and his pain increases with prolonged standing, walking, and sitting. He has difficulty bending forward, backwards, sideways, and driving for prolonged period of time. He has difficulty sleeping and awakens with pain and discomfort. His pain level is constant throughout the day and he has frequent constipation and sexual dysfunction. The patient also complains of left leg pain with radiation into his foot, his leg pain is present 100% of the time. The patient has difficulty standing and walking for a prolonged period. The patient states that his leg has given out causing him to lose his balance. He has difficulty ascending and descending stairs and he walks with an uneven gait. Physical examination identifies spasm and tenderness to palpation over the lumbar paravertebral musculature, tenderness over the sciatic notch, lumbar forward flexion is 40, lumbar extension and bilateral lateral bend is 10, bilateral straight leg raise his positive, and sensory examination in the lower extremities is intact and all dermatomes bilaterally. Diagnoses include status post failed back syndrome and lumbar fusion at L5 - S1 with bilateral upper and lower extremity radiculopathy. The treatment plan recommends removal of spinal cord stimulator, preoperative internal medicine evaluation, clearance, and optimization prior to undergoing the lumbar spine surgical treatment, request for a cold therapy unit for

postoperative home use, request for a lumbar spine orthotic brace for support, request for 24 visits of postoperative physical therapy treatment, request for transportation to and from facility, request for MRIs of the spinal axes preoperatively to delineate what is causing the patient's symptomology, prescription for soma 350 mg b.i.d. #60, and a prescription for Norco 10/325 #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation continuous-flow cryotherapy. Official disability guidelines; neck and upper back (acute & chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/Heat Packs.

Decision rationale: Regarding the request for one cold therapy unit, California MTUS and ODG do not specifically address the issue for the low back, although ODG supports cold therapy units for up to 7 days after surgery for some other body parts. For the back, CA MTUS/ACOEM and ODG recommend the use of cold packs for acute complaints. Within the documentation available for review, there is no documentation of a rationale for the use of a formal cold therapy unit rather than the application of simple cold packs at home during the initial postoperative period. Additionally, the current open-ended request is not supported by guidelines. In the absence of clarity regarding those issues, the currently requested one cold therapy unit is not medically necessary.

Soma 350mg #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; Neck and Upper Back (Acute & Chronic)-Carisoprodol (Soma, Soprodon 350, Vanadom, generic available).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

Decision rationale: Regarding the request for Soma 350mg #60, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Soma specifically is not recommended for more than 2 to 3 weeks. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Soma. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as

recommended by guidelines. In the absence of such documentation, the currently requested Soma 350mg #60 is not medically necessary.

3 view x-ray of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, Chronic Pain Treatment Guidelines Lumbar spine x-rays.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Radiography (X-rays).

Decision rationale: Regarding request for 3-view x-ray of the lumbar spine, Occupational Medicine Practice Guidelines state that x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology even if the pain has persisted for at least 6 weeks. However, it may be appropriate when the physician believes it would aid in patient management. Guidelines go on to state that subsequent imaging should be based on new symptoms or a change in current symptoms. Within the documentation available for review, there is no statement indicating how the patient's symptoms or findings have changed since the time of the most recent imaging. Additionally, the requesting physician has not stated how his medical decision-making will be changed based upon the outcome of the currently requested lumbar x-ray. In the absence of clarity regarding those issues, the currently requested 3-view x-ray of the lumbar spine is not medically necessary.