

Case Number:	CM15-0011615		
Date Assigned:	01/29/2015	Date of Injury:	08/28/2014
Decision Date:	04/13/2015	UR Denial Date:	01/19/2015
Priority:	Standard	Application Received:	01/21/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Internal Medicine

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 24 year old male, who sustained an industrial injury on 8/28/2014. He has reported sharp back pain with radiation to right leg and muscle spasms. The Magnetic Resonance Imaging (MRI) 9/12/14 was significant for L4-5 disc protrusion with 3 millimeter bulge and annular tear. On 1/19/15, he underwent right sided lumbar epidural injection. The diagnoses have included disc protrusion with radiculopathy. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), analgesics, proton pump inhibitor, back brace, home Transcutaneous Electrical Nerve Stimulation (TENS), physical therapy and epidural injection. Currently, the IW complains of low back pain with right lower extremity symptoms rated 7/10 VAS. The provider documented decreased pain of four points and increased ability to complete activities of daily life with use of medications, Transcutaneous Electrical Nerve Stimulation (TENS), home exercise, cold, heat and stretching. Physical examination from 1/5/15 documented lumboparaspinal spasms and tenderness, positive straight leg raise right with pain to foot, and decreased Range of Motion (ROM) in lumbar spine. Plan of care was to continue physical therapy, medications as ordered, Transcutaneous Electrical Nerve Stimulation (TENS) use, and LSO (back brace) to increase tolerance to standing. On 1/19/2015, Utilization Review non-certified a physical therapy three times a week for four weeks for lumbar spine, retrospective thirty day trial Transcutaneous Electrical Nerve Stimulation (TENS), retrospective LSO, Tramadol ER 150mg #30, hydrocodone 10/325mg #30, Naproxen Sodium 550mg one tablet three times a day 90, Pantoprazole 20mg one tablet three times a day #90, and Cyclobenzaprine 7.5mg one tablet three times daily #90, noting the recommended use is for short

term therapy. The MTUS Guidelines were cited. On 1/21/2015, the injured worker submitted an application for IMR for review of physical therapy three times a week for four weeks for lumbar spine, retrospective thirty day trial Transcutaneous Electrical Nerve Stimulation (TENS), retrospective LSO (back brace), Tramadol ER 150mg #30, hydrocodone 10/325mg #30, Naproxen Sodium 550mg one tablet three times a day 90, Pantoprazole 20mg one tablet three times a day #90, and Cyclobenzaprine 7.5mg one tablet three times daily #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 x 4 lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98 - 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Chapter.

Decision rationale: MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of Lumbar sprains and strains and Intervertebral disc disorders without myelopathy. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency (from up to 3 or more visits per week to 1 or less). When the treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. At the time that the additional physical therapy now under review was prescribed, the injured had completed 12 visits of physical therapy. Documentation provided revealed that progress was limited due to pain. Given that the injured worker has had no significant improvement in pain with an initial course of Physical Therapy, the medical necessity for further physical therapy has not been established. The request for Physical therapy 3 x 4 lumbar spine is not medically necessary based on MTUS.

Retrospective request for TENS 30-day trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114.

Decision rationale: MTUS guidelines state that a TENS unit may be recommended in the treatment of chronic intractable pain conditions, if there is documentation of pain for at least three months duration, evidence that other appropriate pain modalities including medications have been tried and failed and that a one-month trial period of the TENS unit has been prescribed, as an adjunct to ongoing treatment modalities within a functional restoration program. Physician report indicates that the injured worker reported previous TENS use was efficacious at physical therapy visits. Documentation fails to show evidence of a functional

restoration program or significant improvement in functional status of the injured worker, who remains disabled from work. The request for Retrospective request for TENS 30-day trial is not medically necessary based on lack of improvement in functional status and by MTUS.

Retrospective request for LSO: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table 12-5 & 12-8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Initial Care, pg 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar supports.

Decision rationale: MTUS states that the use of Lumbar supports to treat low back pain has not been shown to have any lasting benefit beyond the acute phase of symptom relief. Per guidelines, lumbar supports may be recommended as an option for compression fractures and specific treatment of spondylolisthesis and documented instability. Long term use of lumbar supports is not recommended. Chart documentation does not indicate that the injured has a compression fracture and there is lack of objective findings of instability that would justify the continued use of lumbar support. The request for Retrospective request for LSO is not medically necessary per guideline.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol Page(s): 77, 113.

Decision rationale: Tramadol is a centrally acting analgesic reported to be effective in managing neuropathic pain. Per MTUS guidelines, there are no long-term studies to allow use of Tramadol for longer than three months. The injured worker's diagnoses include disc protrusion with radiculopathy with persistent low back pain. Chart documentation shows that Tramadol ER has been prescribed for over three months in addition to other medications. With MTUS guidelines not being met, the request for Tramadol ER 150mg #30 is not medically necessary.

Hydrocodone 10/325mg #30: Overturned

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

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

Decision rationale: MTUS states that opioids are not generally recommended as a first-line therapy for some neuropathic pain. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented during treatment. Assessment for the likelihood that the patient could be weaned from opioids is recommended if there is no improvement in pain and function. The injured worker complaints of low back pain and is diagnosed with disc protrusion with radiculopathy. Physician reports show that there is improved adherence to activities and decreased pain on the medications. The injured worker is reported to have GI upset with NSAIDS and there is no indication of addictive behavior. With Tramadol and NSAIDS not being options for long term use, the continued use of Hydrocodone is appropriate at this time. The request Hydrocodone 10/325mg #30 is medically necessary.

Retrospective request for Naproxen Sodium 550mg 1 TID #90 (DOS: 12/15/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

Decision rationale: Per MTUS guideline, Non-steroidal anti-inflammatory drugs (NSAIDS) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. Documentation provided revealed that the injured worker reports GI upset with NSAIDS, requiring addition of a Proton Pump Inhibitor to medication regimen. The continued use of high dose NSAIDS is not appropriate. Per MTUS guidelines, the retrospective request for Naproxen Sodium 550mg 1 TID #90 (DOS: 12/15/14) is not medically necessary.

Retrospective request for pantoprazole 20mg 1TID #90 (DOS: 12/15/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: MTUS recommends the combination of Non-steroidal anti-inflammatory drugs (NSAIDs) and Proton Pump Inhibitors (PPIs) for patients at risk for gastrointestinal events including age over 65 years of age, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of ASA and high dose or multiple NSAID. Documentation shows that the injured worker reports GI upset with NSAIDS alone and with daily and twice daily dosing of PPIs. Physician reports fail to show significant level of improvement in function to support the continued use of high dose NSAIDs and PPIs. The request for Retrospective request for pantoprazole 20mg 1 TID #90 (DOS: 12/15/14) is not medically necessary.

Retrospective request for cyclobenzaprine 7.5mg #90 1 TID (DOS: 12/15/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

Decision rationale: Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system depressant recommended as a treatment option to decrease muscle spasm in conditions such as low back pain. Per MTUS guidelines, muscle relaxants are recommended for use with caution as a second-line option for only short-term treatment of acute exacerbations in patients with chronic low back pain. The greatest effect appears to be in the first 4 days of treatment and appears to diminish over time. Prolonged use can lead to dependence. Documentation fails to indicate acute exacerbation or significant improvement in the injured worker's functional status to justify continued use cyclobenzaprine. The request cyclobenzaprine 7.5mg #90 1 TID (DOS: 12/15/14) is not medically necessary per MTUS guidelines.