

<b>Case Number:</b>	CM15-0140419		
<b>Date Assigned:</b>	07/30/2015	<b>Date of Injury:</b>	06/04/2003
<b>Decision Date:</b>	08/28/2015	<b>UR Denial Date:</b>	06/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 47 year old male who sustained an industrial injury on 6.4.03 when he fell backwards hitting his head and back on boxes and felt immediate low back pain. He sustained injuries to his head, cervical spine, thorocolumbar spine, testicles, and bilateral upper and lower extremities. He was medically evaluated, given Motrin, ice and physical therapy. On 5.31.04 he was unable to straighten up and was medically evaluated again and received Morphine, x-ray of lumbar spine, MRI of the cervical spine. He currently complains of neck pain radiating down bilateral upper extremities to the hands with tingling and numbness; constant low back pain radiating down the bilateral lower extremities to the feet with numbness; ongoing headaches. His pain level was 7 out of 10 with medications and 10 out of 10 without medications. His activities of daily living are limited in the areas of self-care, hygiene, activity, ambulation, hand function, sleep, sex, due to pain. On physical exam of the cervical spine there was tenderness in the cervical spine C5-7 with decreased range of motion due to pain; lumbar examination revealed tenderness on palpation at L4-S1 with limited range of motion. He ambulates with a cane (per 5.21.15 discussion) due to instability. Medications were Lidoderm 5% Patch; Aspirin; glucosamine complex; Nexium; Norco. Diagnoses include cervical radiculitis; cervical sprain, strain; failed back surgery syndrome, lumbar; lumbar radiculopathy; status post fusion, lumbar spine; status post lumbar laminectomy at L4-5; left ankle pain; gastritis; chronic pain, other; status post spinal cord stimulator implant ; annular tear. Treatments to date include spinal cord stimulator with benefit; transcutaneous electrical nerve stimulator unit was helpful; medications were helpful; home exercise program. Diagnostics include computed

tomography of the cervical spine (12.3.14) showing osteoarthritis, disc protrusion; MRI of the cervical spine (10.14.10) showing disc protrusion; MRI of the cervical spine (4.19.06) showing disc protrusion; electromyography, nerve conduction study (2.9.11) showing mild radiculopathy; MRI of the lumbar spine (1.12.06) showing disc bulge, disc desiccation. In the progress note dated 5.21.15 the treating provider's plan of care includes requests for docusate sodium 100 mg #120 with 3 refills; computed tomography of the thoracic spine; functional restoration program twice per week for six weeks to address lumbar, cervical spine, due to failed lumbar spine and cervical spine surgery.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **1 prescription of Docusate Sodium 100mg, #120 with 3 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for docusate, California Pain Medical Treatment Guidelines support the prophylaxis of constipation for patients undergoing chronic opioid therapy. Within the documentation available for review, it appears that opioids were non-certified and there is no other indication noted for the ongoing use of this medication. In light of the above issues, the currently requested docusate is not medically necessary

#### **12 functional restoration program sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs); Functional restoration programs (FRPs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-34 and 49 of 127.

**Decision rationale:** Regarding the request for a functional restoration program, California MTUS supports chronic pain programs/functional restoration programs when: An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; The patient has a significant loss of ability to function independently resulting from the chronic pain; The patient is not a candidate where surgery or other treatments would clearly be warranted. The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & Negative predictors of success have been addressed. Within the medical information available for review, none of the aforementioned criteria have been documented. In the absence of clarity regarding the above issues, the currently requested functional restoration program is not medically necessary.

**1 CT scan of the thoracic spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-7.

**Decision rationale:** Regarding the request for thoracic CT, CA MTUS and ACOEM guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Within the documentation available for review, there is no indication of any red flags, neurologic deficit, or another clear indication for CT imaging. In the absence of clarity regarding those issues, the currently requested thoracic CT is not medically necessary.