

<b>Case Number:</b>	CM15-0146611		
<b>Date Assigned:</b>	08/07/2015	<b>Date of Injury:</b>	04/30/2007
<b>Decision Date:</b>	09/24/2015	<b>UR Denial Date:</b>	07/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2015

### 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: Emergency 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 56 year old male, who sustained an industrial injury on April 30, 2007. He reported a sudden onset of pain while lifting. The injured worker was currently diagnosed as having postlaminectomy syndrome lumbar region, lumbago, displacement lumbar intervertebral disc without myelopathy, lumbosacral spondylosis without myelopathy and thoracic lumbosacral neuritis radiculitis unspecified. Treatment to date has included physical therapy, epidural steroid injections, medications and surgery. On June 26, 2015, the injured worker complained of pain in the lumbar spine and bilateral lower extremities. He rated his pain as an 8 on a 0-10 pain scale. Medications and rest help to relieve the pain. The pain is made worse by changing position, increased activity, and sneezing. He reported his medications help him perform his activities of daily living to the best of his ability. The treatment plan included medications, walk in bathtub whirlpool installed in the home and a follow-up visit. On July 21, 2015, Utilization Review non-certified the request for spinal cord stimulator permanent implant and trial removal for the lumbar spine as outpatient, citing California MTUS Guidelines. A letter of appeal dated 7/24/15 was reviewed. It states that request was for a trial of spinal cord stimulator and removal and not permanent placement. All other relevant information was reviewed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg QTY: 120.00:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-going management of Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): s 76-79.

**Decision rationale:** Percocet is acetaminophen and Oxycodone, an opioid. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. As per medical records and letter of appeal, it notes that patient has constant severe pain that is poorly controlled but pain medications allow patient to function. A progress note noted significant decreased in function and increased pain after medication denial. While patient's pain and function is not significantly improved, documentation shows that it allows some maintenance in function. Documentation shows appropriate monitoring for abuse and side effects. Continued opioid therapy is medically necessary.

**Flexeril 10mg QTY: 30.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): s 63-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): s 41-42.

**Decision rationale:** Cyclobenzaprine or Flexeril is a muscle relaxant. As per MTUS Chronic pain guidelines, it is recommended for muscle spasms. It is recommended in short term use and has mixed evidence for chronic use with no specific recommendation for chronic use. Patient has been on this medication chronically. The number of tablets requested is not consistent with short term use. Prescription for Flexeril is not medically necessary.

**Ibuprofen 800mg QTY: 60.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-inflammatory Drugs) Page(s): s 67-68.

**Decision rationale:** Ibuprofen or Motrin is a Non-steroidal anti-inflammatory drug (NSAID). As per MTUS Chronic Pain guidelines, NSAIDs is recommended for short term treatment or for exacerbations of chronic pains. It is mostly recommended for osteoarthritis. It may be used for chronic pains but recommendations are for low dose and short course only. There are significant side effects if used chronically such as cardiovascular events. Patient has been on ibuprofen chronically. The number of tablets requested is not consistent with short term use. This prescription for ibuprofen is not medically necessary.

**Methocarbamol 75mg QTY: 60.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): s 63-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): s 64-65.

**Decision rationale:** Robaxin or methocarbamol is a muscle relaxant. As per MTUS guidelines, evidence show that it is no better than NSAIDs and is considered a second line treatment due to high risk of adverse events and due to poor supporting evidence. It is recommended only for short course of treatment for acute exacerbations. Patient has been on this medication chronically. The number of tablets requested is not consistent with short term use. Robaxin is not medically necessary.

**1 spinal cords stimulator permanent implant and trial removal for the lumbar spine:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): s 105-107.

**Decision rationale:** All documentation shows that this request is for a SCS trial only and not for permanent implantation. This review will only review trial placement and will not review or approve permanent placement. As per MTUS Chronic pain guidelines, Spinal Cord Stimulators (SCS) may be recommended under specific conditions. It may be recommended for diagnosis of failed back surgery with failed conservative management. Patient meets criteria for a SCS trial. Patient has failed conservative care and has significant pain and deficits from pain. Patient has completed and has approved psychological clearance. Spinal cord simulator trial is medically necessary.