

Case Number:	CM15-0197367		
Date Assigned:	10/12/2015	Date of Injury:	12/06/2013
Decision Date:	11/20/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/07/2015

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: Anesthesiology

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 33 year old male, who sustained an industrial injury on December 6, 2013. The initial symptoms reported by the injured worker are unknown. The injured worker was currently diagnosed as having cervical degenerative disc disease with loss or lordosis and stenosis C3-4 and C4-5 from disc osteophyte complex and congenital stenosis. Treatment to date has included aqua therapy, physical therapy, diagnostic studies, surgery and medication. On March 15, 2015, computed tomography of the lumbar spine impression was multilevel decompressive laminectomy for severe acquired on congenital spinal canal stenosis with L4-5 interbody fusion with hardware stabilization. On March 15, 2015, computed tomography of the thoracic spine impression was multilevel decompressive laminectomy to relieve severe spinal canal stenosis from acquired on severe central spinal canal stenosis. On August 14, 2015, the injured worker presented for a follow-up visit. He underwent L4-5, L5-S1 posterior instrumented fusion with a T3 through S1 laminectomies on March 9, 2015. His legs were reported to feel stronger. He had residual numbness in the back of the left thigh, outside left calf and bottom of his left foot. His range of motion with flexion at the waist was still very limited. He felt he has 10% capable of performing his job responsibilities. He reported more pain in his lower back than through his thoracic regions. It was about 60% in the lower back and 40% in his thoracic spine. He no longer has radiating leg pain. The treatment plan included MRI of lumbar spine, MRI of thoracic spine, 5-view flexion and extension lumbar and thoracic spine x-ray, Gabapentin, Baclofen and Percocet. On September 28, 2015, utilization review denied a request for an MRI of the lumbar spine, MRI of the thoracic spine, Percocet 10-325mg #30 and Baclofen 10mg #60. A request for Gabapentin 300mg #150 was authorized.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MRI.

Decision rationale: The AECOM Guidelines state that for most true neck and upper back problems, special studies, such as an MRI (magnetic resonance imaging), are not indicated unless a neurologic deficit is documented on physical exam, failure to progress in a strengthening program, or for clarification of the anatomy prior to an invasive procedure. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, there is documentation of the patient's steady postoperative improvement and no postoperative complications. Therefore, there is no specific indication for a repeat MRI of the thoracic spine. Medical necessity for the requested MRI has not been established. The requested imaging is not medically necessary.

Percocet 10/325mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and the ODG, Percocet (Oxycodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. In addition, the MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no documentation of symptomatic benefit, improved pain level, functional improvement, or ability to return to work with previous

opioid treatment. There is no documentation of symptomatic benefit, improved pain level, functional improvement, or ability to return to work with previous opioid treatment. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Baclofen 10mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The California MTUS Guidelines and the ODG recommends non-sedating muscle relaxants, such as Baclofen, with caution as a second-line option for short-term treatment of acute low back pain (LBP), and for short-term (< 2 weeks) treatment of acute exacerbations in patients with chronic LBP. The mechanism of action is blockade of the pre- and post-synaptic GABA receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. It is also a first-line option for the treatment of dystonia. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain. In this case, there is no documentation provided necessitating the use of Baclofen. There is no evidence of objective functional benefit to support any subjective improvements noted. In addition, the cited guidelines do not recommend this medication to be used for longer than 2-3 weeks. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 7/17/15) MRIs (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MRI.

Decision rationale: According to California MTUS Guidelines, MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, there is documentation of the patient's steady postoperative improvement and no postoperative complications. There are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no new neurologic findings on physical exam. Therefore, there is no specific indication for a repeat MRI of the lumbar spine. Medical necessity for the requested MRI has not been established. The requested imaging is not medically necessary.