

Case Number:	CM15-0212677		
Date Assigned:	11/09/2015	Date of Injury:	07/30/2003
Decision Date:	12/18/2015	UR Denial Date:	10/05/2015
Priority:	Standard	Application Received:	10/28/2015

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: New York, Montana, California
 Certification(s)/Specialty: Neurological Surgery

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 60 year old male, who sustained an industrial injury on 7-30-03. The documentation on 9-8-15 noted that the injured worker has complaints of persistent low back pain aggravated by sitting or walking, especially on uneven surfaces. The low back pain is centered over the bilateral sacroiliac joints and radiates across the low back and into both legs. The leg pain is associated with numbness and tingling. The injured worker has complaints of neck pain that radiates into both shoulders and is aggravated by any sort of head movement. The injured workers pain rating has decreased from 8 out of 10 to 6 out of 10 after taking fexmid; from 9 out of 10 to 7 out of 10 after taking Tramadol and from 8 out of 10 to 5 out of 10 after taking Nalfon. The documentation noted that Prilosec helps with the injured workers stomach. Cervical spine reveals tenderness to palpation over the cervical paraspinal musculature and there is decreased range of motion, secondary to pain and stiffness and there is positive spurling's sign bilaterally. Lumbar spine reveals tenderness to palpation over the lumbar paraspinal musculature and there is decreased range of motion secondary to pain and stiffness. There is supine straight leg raise test is positive at 20 degrees bilaterally and there is positive tenderness over the bilateral sacroiliac joints. The diagnoses have included displacement of cervical intervertebral disc without myelopathy; displacement of lumbar intervertebral disc without myelopathy; brachial neuritis or radiculitis not otherwise specified and thoracic or lumbosacral neuritis or radiculitis, unspecified. Treatment to date has included lumbosacral brace for support; compound creams; Fexmid; Nalfon; Prilosec; Ultram; norco; cyclobenzaprine-tramadol topical cream. The documentation noted that the injured worker has been on Prilosec; Ultram ER; Nalfon and norco since at least 3-19-15. The original utilization review (10-5-15) non-certified the request for interspinous fixation at L4-5 and L5-S1 (sacroiliac); retro prilosec (omeprazole DR) 20mg 2x a day #90, date of

service 9-8-15 lumbosacral brace and retro Nalfon (fenoprofen calcium) 400mg #90, date of service 9-8-15. The request for retro Lunesta (eszopiclone) 2mg #30 was modified to #27. The request for retro Ultram ER (Tramadol HCL ER) 150mg #90 was modified to #81. The request for norco (hydrocodone bitartrate and acetaminophen) 10-325mg #30 was modified to #27. The request for physical therapy 2 x 3 for the neck and low back was modified to two visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interspinous fixation at L4-5 and L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: The California MTUS guidelines recommend lumbar surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of these conditions. Interspinous fixation is a type of fusion attempt. The requested treatment: Interspinous fixation at L4-5 and L5-S1 is not medically necessary and appropriate.

Retro Prilosec (Omeprazole DR) 20mg 2x a day #90, DOS: 9/8/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Prilosec (omeprazole) is a proton pump inhibitor which is prescribed to avert gastrointestinal symptoms associated with NSAIDs treatment. Documentation does not provide information to explain why Prilosec is prescribed twice a day. The guidelines recommend the use of the proton pump inhibitor when risk of gastrointestinal events is likely. Documentation does not supply information about the possible risk. The requested treatment: Retro Prilosec (Omeprazole DR) 20mg 2x a day #90, DOS: 9/8/15 is not medically necessary and appropriate.

Associated surgical service: Lumbosacral brace: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Retro Lunesta (Eszopiclone) 2mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness and Stress.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Medications Chapter; Insomnia treatment - eszopicolone.

Decision rationale: Lunesta (Eszopiclone) according to the ODG guidelines is a first-line medication for insomnia. It has the potential for abuse and dependency. But it is the only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. Documentation is not provided to indicate why and whether it is prescribed for short or long-term. The requested treatment: Retro Lunesta (Eszopiclone) 2mg #30 is not medically necessary and appropriate.

Retro Ultram ER (Tramadol HCL ER) 150mg #90: 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, specific drug list.

Decision rationale: The California MTUS guidelines note Tramadol may increase the risk of seizure especially in patients taking SSRIs, TCAs and other opioids. They note the side effects of dizziness, nausea, constipation, headache, and somnolence. The California MTUS Chronic Pain Medical Treatment guidelines note Tramadol is not recommended as a first-line oral analgesic. They note the recommended dose should not exceed 400mg/day. This would occur if the patient took the prescription of 150mg three times a day. The requested treatment: Retro Ultram ER (Tramadol HCL ER) 150mg #90 is not medically necessary and appropriate.

Norco (Hydrocodone Bitartrate & Acetaminophen) 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, criteria for use.

Decision rationale: Documentation indicates recommendations had been made for weaning. Documentation does not furnish evidence these recommendations had been followed. The California MTUS guidelines; Chronic Pain Medical Treatment guidelines recommend the provider monitor the pain relief and the functional improvement the patient gets with the medication. The guidelines advise the lowest possible dose be used for efficacy. The guidelines also caution about the development of habituation and abuse. Documentation does not show this was done. The requested Treatment: Norco (Hydrocodone Bitartrate & Acetaminophen) 10/325mg #30 is NOT Medically necessary and appropriate.

Physical therapy 2 x 3 for the neck and low back: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back and neck chapters-physical therapy.

Decision rationale: The ODG guidelines do allow six visit clinical trial for physical therapy and then assessment about efficacy. For therapy for intervertebral disc displacements 9 visits over 8 weeks are advised. The requested treatment: Physical therapy 2 x 3 for the neck and low back is medically necessary and appropriate.

Retro Nalfon (Fenoprofen Calcium) 400mg #90, DOS: 9/8/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, specific drug list & adverse effects.

Decision rationale: The California MTUS chronic pain medical treatment guidelines advise NSAIDs for short term symptomatic relief. They note that a Cochrane review of the literature on drug relief for low back pain noted that NSAIDs were no more effective than acetaminophen, muscle relaxants and narcotic analgesics. Since this requested treatment exceeds the short-term recommendation, the requested treatment: Retro Nalfon (Fenoprofen Calcium) 400mg #90, DOS 9/8/15 is NOT Medically necessary and appropriate.