

Case Number:	CM14-0149047		
Date Assigned:	09/18/2014	Date of Injury:	03/22/2011
Decision Date:	10/17/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/13/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, and Spinal Cord Medicine and is licensed to practice in Massachusetts. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant has a history of a work injury occurring on 02/01/11, when, working cleaning floors in a restaurant and bending over and pulling a large table she had sharp low back pain which subsequently radiated into the left greater than right leg. She was diagnosed with spondylolisthesis at L4-5. Treatments included medications and chiropractic care. An MRI of the lumbar spine on 09/19/11 was negative for disc herniation. Electromyogram /nerve conduction study EMG/NCS testing in April 2012 showed findings of a left S1 radiculopathy. Subsequent treatments included a spinal cord stimulator trial with benefit. She was seen by the requesting provider on 07/10/14. She was having low back pain radiating into the left leg. Medications included Gabapentin, Omeprazole, Cymbalta, Xanax, and topical creams and patches with some relief. Physical examination findings included decreased lumbar spine range of motion with paraspinal muscle tenderness and left lower extremity weakness with decreased sensation. She was seen for an QME on 07/24/14. She was having severe low back and hip pain with pain radiating into both legs rated at 6-7/10. Recommendations included obtaining a Functional Capacity Evaluation when she had completed her active care. On 08/07/14 pain was rated at 7/10. Medications were providing some pain relief. She was having difficulty sleeping. Physical examination findings included decreased lumbar spine range of motion with lumbar paraspinal muscle tenderness and muscle spasms. There was decreased left lower extremity strength and sensation. She had decided against permanent spinal cord stimulator placement. Topical creams and patches were refilled and authorization for a Functional Capacity Evaluation was requested. She was seen by the requesting provider on 09/11/14. Pain was rated at 7/10. Physical examination findings appear unchanged. Medications were refilled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Evaluation (FCE) for the left lower extremity and lumbar spine:
Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Capacity Evaluations Page(s): 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluations

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 50.

Decision rationale: The claimant is more than 3 years status post work-related injury and continues to be treated for chronic low back pain with radicular symptoms. A spinal cord stimulator trial was completed and the claimant has elected not to undergo permanent implantation. She has spondylolisthesis and has not had surgery. A Functional Capacity Evaluation is an option for a patient with chronic stable low back pain when a physician thinks the information might be helpful to attempt to objectify worker capability with respect to either a specific job or general job requirements. In this case, although the claimant may not be at maximum medical improvement, no new treatment is being planned. Obtaining a Functional Capacity Evaluation to determine the claimant's current work capacity is therefore considered medically necessary.

Topical Creams (not otherwise specified): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The claimant is more than 3 years status post work-related injury and continues to be treated for chronic low back pain with radicular symptoms. Treatments have included unspecified topical creams and patches. Although topical analgesic medications are considered an option in the treatment of chronic pain, in this case, the actual medication being prescribed is not specified and therefore not medically necessary.

Topical Patches #30 (not otherwise specified): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The claimant is more than 3 years status post work-related injury and continues to be treated for chronic low back pain with radicular symptoms. Treatments have included unspecified topical creams and patches. Although topical analgesic medications are considered an option in the treatment of chronic pain, in this case, the actual medication being prescribed is not specified and therefore not medically necessary.

Xanax 0.5mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The claimant is more than 3 years status post work-related injury and continues to be treated for chronic low back pain with radicular symptoms. Treatments have included Xanax being prescribed on a long term basis. Xanax (Alprazolam) is a benzodiazepine which is not recommended for long-term use. Long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Gradual weaning is recommended for long-term users. Therefore the ongoing prescribing of Xanax was not medically necessary.