

Case Number:	CM15-0110544		
Date Assigned:	06/17/2015	Date of Injury:	10/31/2001
Decision Date:	09/01/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/09/2015

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

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 48 year old male with an October 31, 2001 date of injury. A progress note dated May 20, 2015 documents findings (progressive increased lower back pain with associated increase in the left lower extremity radicular pain and weakness; difficulty sleeping), objective findings (well healed surgical scar of the lumbar spine; tenderness to palpation is present with moderate spasm on left greater than right; straight leg raising test positive eliciting symptoms in the left lower extremity over the left foot; decreased sensation in the left L5 and S1 nerve root distributions), and current diagnoses (lumbar spine sprain/strain; thoracic or lumbosacral neuritis or radiculitis; displacement of thoracic or lumbar intervertebral disc without myelopathy). Treatments to date have included therapy/exercise that has provided temporary benefit, lumbar epidural steroid injection, transcutaneous electrical nerve stimulator unit, chiropractic treatment, and medications. The treating physician documented a plan of care that included Ultram, Fexmid, a urine drug screen, and one lumbosacral orthosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) prescription of Ultram (Tramadol) 50mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88, 89.

Decision rationale: The patient presents with low back pain with radiating pain to the left lower extremity. The request is for ONE (1) PRESCRIPTION OF ULTRAM (TRAMADOL) 50MG #120. The request for authorization is dated 05/20/15. The patient is status post L4-L5 microdiscectomy, 08/07/03. Physical examination of the lumbar spine reveals well-healed scar. Tenderness to palpation is present with moderate spasm on left greater than right. Straight leg raising test is positive eliciting symptoms in the left lower extremity over the left foot. There is decreased sensation in the left L5 and S1 nerve root distributions. He states that therapy/ exercise provides temporary benefit only. Patient completed 6 authorized visits of chiropractic treatment. Patient is to complete scheduled physical therapy / rehabilitation then progress to home exercise program. Patient's medications include Tramadol, Gabapentin, Fexmid, Losartan, Clopidogrel, Aspirin and Metoprolol. Per progress report dated 05/20/15, the patient is not working. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS p 77 states, "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS Chronic Pain Medical Treatment Guidelines for Tramadol, page 113 for Tramadol (Ultram) states: Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. For more information and references, see Opioids. See also Opioids for neuropathic pain. Treater does not specifically discuss this medication. Patient has been prescribed Ultram since at least 01/05/15. MTUS requires appropriate discussion of the 4A's, however, in addressing the 4A's, treater does not discuss how Ultram significantly improves patient's activities of daily living with specific examples of ADL's. Analgesia is not discussed, specifically showing significant pain reduction with use of Ultram. No validated instrument is used to show functional improvement. There is no documentation regarding side effects nor documentation regarding aberrant drug behavior. No UDS, CURES or opioid pain contract. Therefore, given the lack of documentation, the request IS NOT medically necessary.

One (1) prescription of Fexmid (Cyclobenzaprine) 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cycloenzaprine (Flexeril, Amrix, Fexmid); Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66.

Decision rationale: The patient presents with low back pain with radiating pain to the left lower extremity. The request is for ONE (1) PRESCRIPTION OF FEXMID (CYCLOBENZAPRINE) 7.5MG #60. The request for authorization is dated 05/20/15. The patient is status post L4-L5 microdiscectomy, 08/07/03. Physical examination of the lumbar spine reveals well-healed scar. Tenderness to palpation is present with moderate spasm on left greater than right. Straight leg raising test is positive eliciting symptoms in the left lower extremity over the left foot. There is decreased sensation in the left L5 and S1 nerve root distributions. He states that therapy / exercise provides temporary benefit only. Patient completed 6 authorized visits of chiropractic treatment. Patient is to complete scheduled physical therapy / rehabilitation then progress to home exercise program. Patient's medications include Tramadol, Gabapentin, Fexmid, Losartan, Clopidogrel, Aspirin and Metoprolol. Per progress report dated 05/20/15, the patient is not working. MTUS pg 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." Per progress report dated 05/20/15, treater's reason for the request is "Tx of spasm to resume activity and function; Tx of Chronic Myofascial Pain per MTUS; Off-Label use for tx of LBP." However, MTUS only recommends short-term use (no more than 2-3 weeks) for sedating muscle relaxants. Patient has been prescribed Fexmid since at least 04/10/15. The request for Fexmid (Cyclobenzaprine) #60 would exceed MTUS recommendation and does not indicate intended short-term use. Therefore, the request IS NOT medically necessary.

One (1) random urine drug screen: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Opioid management Page(s): 43, 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, under Urine drug testing (UDT).

Decision rationale: The patient presents with low back pain with radiating pain to the left lower extremity. The request is for ONE (1) RANDOM URINE DRUG SCREEN. The request for authorization is dated 05/20/15. The patient is status post L4-L5 microdiscectomy, 08/07/03. Physical examination of the lumbar spine reveals well-healed scar. Tenderness to palpation is present with moderate spasm on left greater than right. Straight leg raising test is positive eliciting symptoms in the left lower extremity over the left foot. There is decreased sensation in the left L5 and S1 nerve root distributions. He states that therapy/exercise provides temporary benefit only. Patient completed 6 authorized visits of chiropractic treatment. Patient is to complete scheduled physical therapy/rehabilitation then progress to home exercise program. Patient's medications include Tramadol, Gabapentin, Fexmid, Losartan, Clopidogrel, Aspirin and Metoprolol. Per progress report dated 05/20/15, the patient is not working. While MTUS Guidelines do not specifically address how frequent UDS should be considered for various risks

of opiate users, ODG-TWC Guidelines, Pain (Chronic) Chapter, under Urine drug testing (UDT) Section, provide clear recommendation. It recommends once yearly urine drug screen following initial screening, with the first 6 months for management of chronic opiate use in low-risk patients. Per progress report dated 05/20/15, treater's reason for the request is "to document medication compliance per ODG guidelines." In this case, the patient is prescribed Ultram, which is an opiate. ODG recommends once yearly urine drug screen for management of chronic opiate use in low-risk patients. However, the request for Ultram has not been authorized. Therefore, the request IS NOT medically necessary.

One (1) lumbosacral orthosis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic Chapter, under lumbar supports.

Decision rationale: The patient presents with low back pain with radiating pain to the left lower extremity. The request is for ONE (1) LUMBOSACRAL ORTHOSIS. The request for authorization is dated 05/20/15. The patient is status post L4-L5 microdiscectomy, 08/07/03. Physical examination of the lumbar spine reveals well-healed scar. Tenderness to palpation is present with moderate spasm on left greater than right. Straight leg raising test is positive eliciting symptoms in the left lower extremity over the left foot. There is decreased sensation in the left L5 and S1 nerve root distributions. He states that therapy/exercise provides temporary benefit only. Patient completed 6 authorized visits of chiropractic treatment. Patient is to complete scheduled physical therapy/rehabilitation then progress to home exercise program. Patient's medications include Tramadol, Gabapentin, Fexmid, Losartan, Clopidogrel, Aspirin and Metoprolol. Per progress report dated 05/20/15, the patient is not working. ACOEM Guidelines page 301 on lumbar bracing states, "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ACOEM guidelines further state that they are not recommended for treatment, but possibly used for prevention if the patient is working. ODG Low Back - Lumbar & Thoracic Chapter, lumbar supports topic, states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." For post-operative bracing, ODG states, "Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician." Per progress report dated 05/20/15, treater's reason for the request is to "Increase ADL's; Reduce Work Restrictions; Reduce pain level 3-4 pts on 0-10 scale; Reduce Medication Use." However, guidelines recommend lumbar bracing only for the acute phase of symptom relief, compression fractures, treatment of spondylolisthesis and documented instability. No evidence of aforementioned conditions is provided for this patient. There is no evidence of recent back surgery, either. For non-specific low back pain, there is very low quality evidence, and ACOEM guidelines do not support the use of a back brace for chronic pain. Therefore, the request IS NOT medically necessary.

