

Case Number:	CM14-0114290		
Date Assigned:	08/04/2014	Date of Injury:	05/19/2008
Decision Date:	10/08/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/22/2014

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 & Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 54 year old male was reportedly injured on May 19, 2008 to his lower back and left lower extremity. The most recent progress note, dated July 14, 2014, indicates that there were ongoing complaints of low back pain. The physical examination reported findings of muscle spasm, and no other narrative findings are reported. A more comprehensive progress note was dated June 23, 2014 and indicated ongoing complaints of low back pain. Diagnostic imaging studies noted a multiple level lumbar fusion surgery, with no evidence of stenosis. Electrodiagnostic testing identified an abnormal study that demonstrated a L5 to S1 radiculopathy. Previous treatment included physical therapy, multiple medications and other pain management interventions. A request was made for physical therapy, Xrays, and multiple medications was not certified in the preauthorization process on July 1, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-Ray of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines), Indications for imaging - Plain X-rays

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: As noted in the Medical Treatment Utilization Schedule (MTUS), plain films are recommended for acute low back pain. Given the date of injury, the surgery rendered, and the finding on physical examination, there is no clear clinical indication for a repeat Xray of the lumbar spine. It is noted that the symptoms are getting worse, and there is a physical examination support for such an assessment. Therefore, this is not medically necessary.

Ultram 50mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113.

Decision rationale: As noted in the Medical Treatment Utilization Schedule (MTUS), this is a centrally acting synthetic opioid analgesic and not recommended as a first-line oral analgesic. There is no indication that there has been a failure of first line drugs. If anything, the progress notes indicate continuing prescription of such a medication. As such, when noting there is no objectified efficacy or utility for this medication and the premise noted in the MTUS in terms of increased functionality or decrease of the malady and seeing neither, there is no clear clinical indication presented to support the need for this medication. The request is not medically necessary.

Physical Therapy x12 for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter Official Disability Guidelines (ODG), (<http://www.odg-twc.com/preface.htm#PhysicalTherapyGuidelines>)

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: When noting the date of injury, the injury sustained, the treatment rendered, and the multiple sessions of physical therapy completed, there is no data presented to suggest that the home exercise protocol, which is supported in the Medical Treatment Utilization Schedule (MTUS) after lumbar fusion surgery, has not been dealt with. Therefore, based on the ongoing complaints of pain and by the physical examination findings, and noting the metaphysical therapy order completed, there is no clear clinical indication to support the medical necessity of repeating this therapy. Therefore the request is not medically necessary.

Zanaflex 2mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), non-sedating muscle relaxants

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha 2 adrenergic agonist that is Food and Drug Administration (FDA) approved for management of spasticity. It is unlabeled for use in low back pain. Muscle relaxants are only indicated as second line options for short-term treatment. It appears that this medication is being used on a chronic basis, which is not supported by Medical Treatment Utilization Schedule (MTUS) treatment guidelines. Furthermore, while noting that there is muscle spasm on physical examination, this is not spasticity. As such, there is no clinical indication presented. Therefore, this medication is not medically necessary.

Ambien 10mg #15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter 3, Ambien (zolpidem)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG pain chapter updated October, 2014

Decision rationale: The parameters noted in the Official Disability Guidelines (ODG) are employed. This is a nonbenzodiazepine hypnotic medication, which is approved for short term (usually two to six weeks) for the treatment of insomnia. This is not intended for a chronic, indefinite use. While noting that sleep hygiene is a crucial portion of treatment and the chronic pain situation, this medication is not intended for daily indefinite use. Therefore, based on the clinical information, presented for review, this is not medically necessary.

Vicodin 5/500mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

Decision rationale: This medication is a short acting opioid indicated for the management controlling moderate to severe pain. However, the Medical Treatment Utilization Schedule (MTUS) also requires the lowest possible dose that allows for a reduction in pain symptomatology and increase in functionality be employed. Based on the progress notes presented, there is no increase in functionality and the pain levels have not been decreased. Therefore, the efficacy of this preparation has not been objectified. As such, there is no clear clinical indication presented to the indefinite use of this medication and the medical necessity has not been established. Therefore the request is not medically necessary.

