

Case Number:	CM13-0003019		
Date Assigned:	06/16/2014	Date of Injury:	02/28/2000
Decision Date:	07/31/2014	UR Denial Date:	07/11/2013
Priority:	Standard	Application Received:	07/24/2013

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 Occupational Medicine, and is licensed to practice in California. 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 was injured on 02/28/00. She had a low back injury with CRPS. A partial discectomy at L4-5, Restoril, and Valium have all been requested. She was diagnosed with severe stenosis at C5-6 and severe left arm pain and underwent anterior cervical discectomy at C5-6 on 06/26/12. She was taking Topamax, Valium, Oxycodone, and Temazepam at that time. She did well postoperatively but then her pain began to increase again. She saw [REDACTED] for pain management on 08/01/12. She required multiple medications. A partial discectomy was recommended by [REDACTED] on 06/26/13. She had selective nerve root blocks that gave her pain relief and [REDACTED] stated this meant that that was the painful level. On that date, only her neck and upper extremities were examined. On 07/29/13, she was seen for routine follow-up by [REDACTED]. [REDACTED]. She still had spasms in her low back and high pain levels with constant aching. She was status post an injection to her neck. Her medications included Valium, OxyContin, Topamax, Zofran, Imitrex, and Restoril. She stated her oral pain medications were effective in decreasing her pain to a manageable level and she could do her activities of daily living. She has had epidurals in 2013. She saw [REDACTED] on 09/04/13. She looked and felt great. Her lumbar radiculopathy was not mentioned and her low back and legs were not examined. Additional x-rays were recommended. There are no recent clinical notes and no notes since 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

PARTIAL DISCECTOMY LEFT L4-5: Upheld

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

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

Decision rationale: The history and documentation do not objectively support the request for a partial discectomy at level L4-5 on the right side. The CA MTUS state referral for surgical consultation is indicated for patients who have: 1. Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise 2. Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms 3. Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair 4. Failure of conservative treatment to resolve disabling radicular symptoms If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and, especially, expectations is very important. Patients with acute low back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may help resolve the symptoms. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as the second edition of the Minnesota Multiphasic Personality Inventory (MMPI 2). In addition, clinicians may look for Waddell signs during the physical exam. Many patients with strong clinical findings of nerve root dysfunction due to disk herniation recover activity tolerance within one month; there is no evidence that delaying surgery for this period worsens outcomes in the absence of progressive nerve root compromise. With or without surgery, more than 80% of patients with apparent surgical indications eventually recover. Although surgery appears to speed short to mid term recovery, surgical morbidity (recovery and rehabilitation time and effects) and complications must be considered. Surgery benefits fewer than 40% of patients with questionable physiologic findings. Moreover, surgery increases the need for future surgical procedures with higher complication rates. In good surgery centers, the overall incidence of complications from first time disk surgery is less than 1%. However, for older patients and repeat procedures, the rate of complications is dramatically higher. Patients with comorbid conditions, such as cardiac or respiratory disease, diabetes, or mental illness, may be poor candidates for surgery. Comorbidity should be weighed and discussed carefully with the patient. Following surgery, exercise is much better than manipulation for rehabilitation. In this case, the claimant's current status relative to her low back complaints is unknown. The claimant's file ends in 2013 and [REDACTED] stated on 09/04/13 that she looked and felt great. The ESI was recommended before that date. There is no mention of lumbar radiculopathy at that visit. The medical necessity of has not been clearly demonstrated. A clarification/modification was not obtained. There is no clear evidence that her symptoms did not respond to conservative treatment. The medical necessity of this request has not been demonstrated.

VALIUM 10 MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS, Page(s): 74-95.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, page 54 Page(s): 54.

Decision rationale: The history and documentation do not objectively support the request for continued use of Valium. The MTUS state benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Also, before prescribing any medication, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days. A record of pain and function with the medication should be recorded. (Mens 2005) In this case, the indications for ongoing use of Valium have not been described and the

RESTORIL 15 MG #60: 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 Benzodiazepines Page(s): 54.

Decision rationale: The history and documentation do not objectively support the request for continued use of Restoril. The MTUS state benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Also, before prescribing any medication, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days. A record of pain and function with the medication should be recorded. (Mens 2005) In this case, the indications for ongoing use of Restoril have not been described and the medical necessity has not been demonstrated.

