

Case Number:	CM13-0042119		
Date Assigned:	03/26/2014	Date of Injury:	04/01/2003
Decision Date:	08/06/2014	UR Denial Date:	09/15/2013
Priority:	Standard	Application Received:	09/17/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and Texas. 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 injured worker is a 58-year-old female who reported an injury on 08/13/2007. The injury reported was while the injured worker was lifting an 80-pound trash can. Diagnoses included lumbosacral strain/disc disease, right knee strain, left knee strain/internal derangement/chondromalacia, and lumbar radiculopathy. The previous treatments included an MRI, physical therapy, medications, acupuncture, and surgery. Within the clinical note dated 09/03/2013, it was reported the injured worker complained of severe low back pain with traveling pain to her lower extremity. She reported she had numbness, tingling, and weakness. Upon the physical examination of the lumbar spine, the provider noted tenderness at the spinous process of L1 through S1. The injured worker had paravertebral muscle spasms; tenderness of the bilateral sacroiliac joints and buttocks. The provider noted flexion was at 30 degrees and extension at 10 degrees. Upon examination of the lower extremities, the provider noted tenderness of the sciatic nerves bilaterally down to the calves. The provider indicated deep tendon reflexes were 1+ and symmetrical on both knees and right ankle, and absent on the left ankle. The provider requested an MRI, EMG, NCS, Zantac, Ambien, and Voltaren gel. However, a rationale was not provided for clinical review. The Request for Authorization was submitted and dated on 09/12/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 53.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for an MRI of the lumbar spine is not medically necessary. The California MTUS/ACOEM Guidelines state clinical objective findings that identify specific nerve compromise on the neurological exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery as an option. When the neurological examination is less clear; however, further physiological evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in a false positive finding, such as a disc bulge, that are not the source of a painful symptom and do not warrant surgery. Imaging studies should be reserved for cases in which surgery is considered or red flag diagnoses are being evaluated. There is a lack of documentation regarding the failure of conservative treatment. There is a lack of documentation of significant objective findings which would demonstrate neurological deficits. In addition, there is no indication of red flag diagnoses or the intent to undergo surgery requiring an MRI. The provider's rationale was not provided. The medical necessity for imaging was not established. Therefore, the request for an MRI of the lumbar spine is not medically necessary.

EMG OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for an EMG of the bilateral lower extremities is not medically necessary. The California MTUS/ACOEM Guidelines note electromyography (including H-reflex tests) may be useful to identify subtle, focal neurological dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. Discography is not recommended for assessing patients with acute low back symptoms. There is a lack of significant neurological deficits such as decreased sensation or motor strength in a specific dermatomal distribution. There is a lack of significant objective findings indicating the injured worker had symptoms of radiculopathy. Therefore, the request for an EMG of the bilateral lower extremities is not medically necessary.

NCS OF THE BILATERAL LOWER EXTREMITIES: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Nerve Conduction Studies.

Decision rationale: The request for NCS of the bilateral lower extremities is not medically necessary. The Official Disability Guidelines do not recommend a nerve conduction study to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative or to differentiate radiculopathy from other neuropathies or non-neuropathic process if other diagnoses may be based on the clinical exam. There is minimal justification for performing nerve conduction studies when the patient is already presumed to have symptoms on the basis of radiculopathy. The clinical documentation submitted indicated the injured worker was diagnosed with radiculopathy. The guidelines do not support a nerve conduction study for signs and symptoms or diagnosis of radiculopathy. Therefore, the request is not medically necessary.

PRESCRIPTION OF ZANTAC 150MG, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68-69.

Decision rationale: The request for Zantac 150 mf #60 is not medically necessary. The California MTUS Guidelines recommend that clinicians utilize the following criteria to determine if the injured worker is at risk for gastrointestinal events, including over the age of 65, history of peptic ulcer, gastrointestinal bleeding or perforation, current use of aspirin, corticosteroids, and/or anticoagulants The guidelines note the medication is used for the treatment of dyspepsia secondary to NSAID therapy. The medical documents did not indicate the injured worker was at risk for GI bleed or perforation. Additionally, there is a lack of clinical documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. The request submitted failed to provide the frequency of the medication. There is a lack of documentation within the medical records indicating the efficacy of the medication, as evidenced by significant functional improvement. Therefore, the request is not medically necessary.

PRESCRIPTION OF AMBIEN 10MG, #10: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN, ZOLPIDEM.

Decision rationale: The prescription of Ambien 10 mg #10 is not medically necessary. The Official Disability Guidelines note zolpidem, also known as Ambien, is a prescription short-acting non-benzodiazepine hypnotic, which was approved for short-term, usually 2 to 6 weeks, and treatment of insomnia. The guidelines note proper sleep hygiene is critical to the individual with chronic pain and is often hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely if ever recommend them for long-term use. They can be habit-forming and may impair function and memory more than opioid pain relievers. There is also a concern that they may increase pain and depression over the long term. There is a lack of documentation indicating the injured worker has been treated for or diagnosed with insomnia. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication since at least 2007, which exceeds the guidelines' recommendations for short-term use of 2 to 6 weeks. Therefore, the request is not medically necessary.

ONE PRESCRIPTION OF VOLTAREN GEL: 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 TOPICAL NSAIDS Page(s): 111-112.

Decision rationale: The request for 1 prescription of Voltaren gel is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for the use of osteoarthritis and tendonitis, in particular, that of the knee and/or elbow, and other joints that are amenable. Topical NSAIDs are recommended for short-term use of 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder. The guidelines note Voltaren gel has not been evaluated for the treatment of the spine, hip, or shoulder. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency and quantity of the medication. The request submitted does not specify a treatment site. Additionally, the injured worker has been utilizing the medication since at least 2007, which exceeds the guidelines' recommendation of short-term use of 4 to 12 weeks. Therefore, the request is not medically necessary.