

Case Number:	CM13-0058471		
Date Assigned:	03/31/2014	Date of Injury:	05/12/2007
Decision Date:	05/14/2014	UR Denial Date:	11/08/2013
Priority:	Standard	Application Received:	11/27/2013

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 patient is a 34-year-old female who was injured on 05/12/2007 while in a bent position she turned to her left and as she twisted she felt a sudden sharp pain in her lower back. Prior treatment history includes epidural steroid injections and intradiscal electro-thermal cauterization (IDET), which was successful. On 09/19/2010 she had implanted epidural stimulation leads. On 06/17/2013 the patient underwent status post removal of spinal cord stimulation system. The patient underwent carpal tunnel release in 2004, left ulnar release in 2005 and right De Quervain's disease in 1995. Her medications include 2009-2010 anti-depressant and chronic pain medication, Cymbalta. In 2010 treatment was changed to Prozac and Ambien. Also the patient's medication includes 2009 Oxycontin 20 mg, Methadone and Neurontin. The diagnostic studies reviewed include MRI of the lumbar spine dated June 2007 disclosed annular disc injuries at L4-5 and L5-S1. On 09/18/2008 discography at L3-4, L4-5, and L5-S1 under fluoroscopy revealed 3-4 normal disc, right posterolateral fissure and L5-S1 midline posterior fissure. MRI lumbar spine February 2010 revealed mild disc desiccation at L3-4 and L4-5, which has progressed since 2007. No focal disc protrusion or spinal/neural foraminal canal stenosis. A urine toxicology report dated 11/04/2013 was positive for the detection of morphine and hydromorphone, which is a consistent result. Internal medicine AME dated 07/12/2013 documented the patient was diagnosed with suspected sleep apnea and/or architecture sleep/arousal disturbance, pending polysomnographic confirmation. Cognitive Behavioral Therapy note stated the patient continues to demonstrate anger, anxiety, depression and frustration with her physical dysfunction, lack of control of her chronic pain and the medical disappointments and inconsistencies of her condition. The progress note dated 11/04/2013 documented the patient with complaints of low back pain and right lower extremity pain mainly in the foot. Her functional status reveals she can sit for 15-30 minutes, stand 15-25 minutes, walk

15-25 minutes and is up 2 to 3 times a night with sleeping. The objective findings on exam revealed neurological and extremities within normal limits. The diagnoses are lumbar degenerative disc disease, right lower extremity radicular pain, LA/SA, myofascial spasm and disabled. The treatment plan & current medications are MS Contin, Dilaudid, Ambien, Cymbalta, Zanaflex, Prilosec, Gabapentin continue and Senekot.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MRI OF THE LUMBAR SPINE: 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.

Decision rationale: The patient underwent lumbar MRI in 2007 and another in February 2010, which revealed mild disc desiccation at L3-4 and L4-5. No focal disc protrusion or spinal/neural foraminal canal stenosis. The Official Disability Guidelines state repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, and recurrent disc herniation). According to the 11/04/2013 progress report, objective findings on exam revealed neurological exam and extremities within normal limits. The medical records do not reveal significant change or objective findings suggestive of significant pathology. Medical necessity is not established, and lumbar MRI is non-certified.

1 SURGICAL EVALUATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296.

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

Decision rationale: The California MTUS ACOEM guidelines state physical examination evidence of severe neurologic compromise that correlates with the medical history and test results may indicate a need for surgical consultation. Diagnostic studies reviewed include lumbar MRI which showed mild disc desiccation at L3-4 and L4-5 and no focal disc protrusion or spinal/neural foraminal canal stenosis. The medical records do not establish the patient has a surgical lesion revealed on an imaging study. Furthermore, the 11/04/2013 progress report revealed the neurological exam and extremities within normal limits. The medical records do not establish this patient is a surgical candidate. Consequently, the medical necessity of a surgical evaluation has not been established.

SEKOKOT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Regarding long-term opioid management, the guidelines recommend routine re-assessment, which should include documentation of any adverse effects with the medications. The medical records do not appear to document any adverse effects, such as constipation, with her medication regimen. Further, long-term use of Senokot is not indicated. Medical necessity is not established, and Senokot is non-certified.

1 PRESCRIPTION DILAUDID 4 MG #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The patient has normal examination findings. The records do not document the existence of moderately severe pain levels. There is no mention of use of non-opioid and non-pharmacologic means of managing pain. In addition, the medical records do not establish this patient obtained clinically significant pain relief or functional improvement from Dilaudid use. Furthermore, the total daily MED of Dilaudid and MS Contin exceeds the 120 mg maximum as recommended by the guidelines. Given all of these factors, the medical necessity of Dilaudid has not been established.

1 PRESCRIPTION AMBIEN 10MG/ DAY: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Insomnia Treatment

Decision rationale: According to Official Disability Guidelines, Ambien is indicated for short term treatment of insomnia with difficulty of sleep onset, 7-10 days and is indicated for treatment of insomnia with difficulty of sleep onset and/or maintenance. The medical records document the patient complains of low back pain with right lower extremity pain mainly into the foot. A review of the medical records does not reveal any subjective report of sleep difficulties. The medical records submitted do not document any subjective complaints or corroborative clinical objective findings as to establish an active diagnosis of insomnia. There is no clear indication for Ambien. Medical necessity is not established.

1 PRESCRIPTION CYMBALTA 60MG/DAY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 15-16.

Decision rationale: According to the guidelines, Cymbalta is FDA-approved for anxiety, depression, diabetic neuropathy and fibromyalgia. A review of the medical records does not reveal the patient has any of these diagnoses. The patient's listed diagnoses are: 1. Lumbar degenerative disc disease; 2. Right lower extremity radicular pain; 3. LA/SA; 4. Myofascial spasm; and 5. Disabled. There is no high quality evidence to support the use of this medication for lumbar radiculopathy. Furthermore, objective findings on exam revealed neurological exam and extremities within normal limits. Medical necessity is not established, and Cymbalta is non-certified.

1 PRESCRIPTION ZANAFLEX 4MG FOUR TIMES A DAY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: The California MTUS recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Long-term use is not recommended. Functional benefit is not established in this case. Zanaflex is non-certified.

GABAPENTIN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDS) Page(s): 16,18.

Decision rationale: According to the California MTUS guidelines, an anti-epilepsy drug (AED), such as Gabapentin, is recommended for neuropathic pain (pain due to nerve damage). Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The medical records do not establish the patient has neuropathic pain. There are no documented specific subjective complaints or objective clinical findings or electrodiagnostic evidence to suggest radiculopathy. Furthermore, there is not documented benefit with use of Gabapentin,

such as reduction in pain, reduction in opioid use, and functional improvement. The medical necessity of Gabapentin has not been established.

PRILOSEC: 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.

Decision rationale: According to the California MTUS guidelines, PPI "Omeprazole" is recommended if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. The medical records reviewed do not document any gastrointestinal complaints. The patient is less than 65, and in the absence of any history of GI bleeding, concurrent use of ASA, corticosteroid and/or anticoagulant, or high dose or multiple NSAID, the request is not medically necessary according to the guidelines.

MS CONTIN 60MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Specific Drug List; Opioids, Criteria For Use Page(s): 93; 78.

Decision rationale: The medical records do not establish continuous moderately severe pain levels necessitating use of MS Contin. The documentation of utilization of non-opioid methods of pain control is lacking. In addition, there is no documentation of pain levels with and without medication use, establishing clinically significant improved pain levels. Functional benefit is not established. Furthermore, the total daily MED of Dilaudid and MS Contin exceeds the 120 mg maximum as recommended by the guidelines. Based on these factors, continuation of MS Contin is not supported by the evidence based guidelines is not recommended.