

Case Number:	CM14-0100358		
Date Assigned:	09/16/2014	Date of Injury:	06/06/2001
Decision Date:	10/15/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	06/30/2014

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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 45 year old employee with date of injury of 6/6/2001. Medical records indicate the patient is undergoing treatment for s/p lumbar surgery (no date specified); stenosis, lumbar spine; lumbar facet arthropathy; lumbar discogenic spine pain and failed back surgery syndrome. Subjective complaints include pain across the back. He can function with his medication regimen. His pain is dull, aching, throbbing, pressure and cramping with spasm. It is aggravated by cold, activity, sitting, lying down and rest. He gets relief from heat, cold, activity, rest, sitting, walking, massage, TENS unit and medication. Currently, he rates his pain as an 8/10. Objective findings include a normal gait; sitting straight leg raise was positive on both sides, on the right side, back only. Lumbar spine had diffuse tenderness and spasm. The spasms were bilateral in the lumbar spine as he had decreased sensation to touch on lower left extremity. Treatment has consisted of Vicodin; Adderall; ibuprofen; hydrocodone-acetaminophen; Norco; deep tissue massage; home exercise, stretching and moist heat, deep tissue massage for myofascial pain. The utilization review determination was rendered on 6/27/2014 recommending non-certification of a Urine Toxicology Screen [82145x1, 83925x2, 82205x1, 80154x1, 82520 x1, 63840 x1, 83992 x1, 82542 x1, 82055 x1, 82570 x1, 84999 x1(unlisted chem)]; Ibuprofen 800mg #90 with 1 refill; Hydrocodone/ Acetaminophen 5/325mg #60 with 1 refill; Lumbar Transforaminal Epidural Steroid Injection; Magnetic Resonance Imaging (unspecified) and for Deep Tissue Massage (unspecified).

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine Toxicology Screen [82145x1, 83925x2, 82205x1, 80154x1, 82520 x1, 63840 x1, 83992 x1, 82542 x1, 82055 x1, 82570 x1, 84999 x1(unlisted chem)]: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and Substance abuse Page(s): 74-96; 108-109. Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009), pg 32 Established Patients Using a Controlled Substance

Decision rationale: MTUS states that use of urine drug screening for illegal drugs should be considered before therapeutic trial of opioids are initiated. Additionally, "Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion)." would indicate need for urine drug screening. There is insufficient documentation provided to suggest issues of abuse, addiction, or poor pain control by the treating physician. University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009 recommends for stable patients without red flags" Twice yearly urine drug screening for all chronic non-malignant pain patients receiving opioids - once during January-June and another July-December". The patient has been on chronic opioid therapy. The treating physician has not indicated why a urine drug screen is necessary at this time and has provided no evidence of red flags, a signed pain contract, poor pain control, evidence of drug addiction, or drug abuse. As such, the request for Urine Toxicology Screen [82145x1, 83925x2, 82205x1, 80154x1, 82520 x1, 63840 x1, 83992 x1, 82542 x1, 82055 x1, 82570 x1, 84999 x1(unlisted chem)] is not medically necessary.

Ibuprofen 800mg #90 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Meloxicam, NSAIDs Page(s): 67-72.

Decision rationale: MTUS recommends the use of NSAIDS for the acute exacerbation of back pain at the lowest effective dose for the shortest amount of time due to the increased cardiovascular risk, renal, hepatic and GI side effects associated with long term use. MTUS states "Ibuprofen (Motrin, Advil [OTC], generic available): 300, 400, 600, 800 mg. Dosing: Osteoarthritis and off-label for ankylosing spondylitis: 1200 mg to 3200 mg daily. Individual patients may show no better response to 3200 mg as 2400 mg, and sufficient clinical improvement should be observed to offset potential risk of treatment with the increased dose. Higher doses are generally recommended for rheumatoid arthritis: 400-800 mg PO (Orally) 3-4 times a day, use the lowest effective dose. Higher doses are usually necessary for osteoarthritis. Doses should not exceed 3200 mg/day. Mild pain to moderate pain: 400 mg PO every 4-6 hours

as needed. Doses greater than 400 mg have not provided greater relief of pain". The treating physician did not document a decrease in pain or functional improvement from the use of Ibuprofen. Ibuprofen is not recommended for long term use due to its GI side effects and increased cardiovascular risk. As such the request for Ibuprofen 600mg, #90 is not medically necessary.

Hydrocodone/ Acetaminophen 5/325mg #60 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids, Pain

Decision rationale: ODG does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. The utilization reviewer approved 60 tablets without a refill, since abrupt cessation of narcotics is not recommended. As such, the question for Hydrocodone/ Acetaminophen 5/325mg #60 with 1 refill is not medically necessary.

Lumbar Transforaminal Epidural Steroid Injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) . . . Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." While the treating physician does document a home exercise program, the treating physician does not detail the success or failure of the home exercise program (increased functionality, improve or decreased range of motion).

Additionally, no objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using Transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The treating physician has not documented motor weakness, muscle atrophy, dermatomal sensory deficit, an MRI showing nerve root compression or abnormal EMG/NCV of the lower extremities. Additionally, treatment notes do not indicate if other conservative treatments were tried and failed (exercises, physical therapy, etc.). Also, the number of levels and sites was not detailed. As such, the request for Lumbar Epidural Steroid Injection is not medically necessary.

Magnetic Resonance Imaging (unspecified): 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 Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging)

Decision rationale: MTUS and ACOEM recommend MRI, in general, for low back pain when "cauda equine, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative, MRI test of choice for patients with prior back surgery" ACOEM additionally recommends against MRI for low back pain "before 1 month in absence of red flags". ODG states, "Imaging is indicated only if they have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms." The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags, significant worsening in symptoms or other findings suggestive of the pathologies outlined in the above guidelines. Based on the diagnosis provided it appears the request would be for a Lumbar MRI, but the treating physician did not

specify the body part for the MRI. As such, the request for MRI lumbar spine is not medically necessary.

Deep Tissue Massage (unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Massage Therapy, Manual Therapy

Decision rationale: MTUS states regarding massage therapy, "Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases." ODG offers additional frequency and timeline for massage therapy by recommending: a. Time to produce effect: 4 to 6 treatments.b. Frequency: 1 to 2 times per week for the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks.c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life.The treating physician did not specify a timeline for therapy, deficits to be addressed, the body location to be treated and the measurable goals of the massage therapy. Additionally, MTUS discourage the use of passive modalities for therapy. As such, the request for Massage Therapy (Unspecified) is not medically necessary at this time.