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| Case Number: | CM14-0012367 | | |
| Date Assigned: | 02/21/2014 | Date of Injury: | 03/15/2013 |
| Decision Date: | 07/29/2014 | UR Denial Date: | 01/23/2014 |
| Priority: | Standard | Application Received: | 01/30/2014 |

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 Orthopedic Surgery 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:

This 34-year-old male sustained an industrial injury on 3/15/13. The injury was sustained when he lifted an unresponsive co-worker off the ground and into a wheelchair. The 7/29/13 bilateral lower extremity EMG/NCV study documented findings of moderately acute S1 radiculopathy on the right and possibly on the left. There was no evidence of peripheral neuropathy. The 9/10/13 lumbar MRI impression documented multilevel degenerative disc disease worsened from the prior study in 2008. There was a new left posterolateral disc herniation at L5/S1 posteriorly displacing the left S1 nerve root. There was scattered facet joint arthropathy, worse at the lower levels. The 11/11/13 thoracic MRI impression documented multilevel degenerative disease with small posterior disc bulges. There was no spinal canal or neuroforaminal stenosis. The 1/3/14 treating physician report cited grade 8/10 back pain with difficulty falling and staying asleep. The patient had 6 chiropractic sessions with improvement in pain. Thoracolumbar exam documented normal gait, thoracic paravertebral muscle tenderness, flexion 30 degrees, extension 20 degrees, normal lower extremity sensation, and positive left straight leg raise. The treatment plan recommended bilateral lower extremity EMG, additional physical therapy and chiropractic, and thoracic epidural steroid injection. Medications were dispensed. The 1/23/14 utilization review denied the medication requests based on an absence of medical indications consistent with guidelines and/or absent guideline support for the medication class. The bilateral lower extremity EMG request was denied based on the absence of red flags since the prior study to warrant a repeat study.

IMR ISSUES, DECISIONS AND RATIONALES

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

QUAZEPAM 15MG QTY: 30.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The MTUS Chronic Pain Guidelines does not recommend the use of benzodiazepines, like Quazepam, for long-term use. Most guidelines limit use to 4 weeks. Chronic benzodiazepines are the treatment of choice in very few conditions. The continued use of this medication is not supported by the MTUS Chronic Pain Guidelines. Records indicate that this medication was prescribed on 11/12/13. There is no documentation of any specific benefit or indication for continued use. Sleep appears to have worsened. As this medication was dispensed, there is no concern for weaning. Therefore, this request for Quazepam 15 mg #30 is not medically necessary.

PANTOPRAZOLE SODIUM 20MG QTY: 60.00: 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 NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton pump inhibitors (PPIs).

Decision rationale: The MTUS Chronic Pain Guidelines recommend the use of proton pump inhibitors (PPIs), such as Protonix, for patients at risk for gastrointestinal events. Risk factors include age greater than 65 years, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (non-steroidal anti-inflammatory drug). PPIs are reported highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. The Official Disability Guidelines recommend Protonix as a second-line medication if a trial of omeprazole is not effective. Guideline criteria for intermediate gastrointestinal risk factors have not been met. There is no evidence that this injured worker has a history of peptic ulcer, gastrointestinal bleeding or perforation, or has experienced dyspepsia with NSAID use. Additionally, there is no documentation that a trial of omeprazole for gastrointestinal symptoms failed. Therefore, this request is not medically necessary.

MENTHODERM GEL 120 GRAMS QTY: 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: The MTUS Chronic Pain Guidelines for topical analgesics state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines state that the efficacy in clinical trials for topical non-steroidal anti-inflammatory drug (NSAIDs) has been inconsistent and most studies are small and of short duration. Guidelines recommend the use of topical NSAIDs for osteoarthritis and tendinitis, particularly of the knee and elbow or other joints that are amenable to topical treatment, limited to 4 to 12 weeks. Guideline criteria have not been met. The continued use of Methoderm gel is not supported by the MTUS Chronic Pain Guidelines for use in spinal complaints. As such, the request is not medically necessary and appropriate.

ELECTROMYOGRAPHY (EMG) OF RIGHT LOWER EXTREMITY QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 303, 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309.

Decision rationale: The ACOEM Guidelines state that EMG may be used to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. EMG is not recommended for clinically obvious radiculopathy. The ACOEM Guideline criteria have not been met. There is electrodiagnostic evidence of radiculopathy that has been consistent with clinical exam findings. There is no documentation of a worsening clinical presentation to warrant a repeat of the EMG study performed six months prior. Therefore, this request for electromyography (EMG) of right lower extremity is not medically necessary.

ELECTROMYOGRAPHY (EMG) OF LEFT LOWER EXTREMITY QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 303, 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309.

Decision rationale: The ACOEM Guidelines state that EMG may be used to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. EMG is not recommended for clinically obvious radiculopathy. Guideline criteria have not been met. There is electrodiagnostic evidence of radiculopathy that has been consistent with clinical exam findings. There is no documentation of a worsening clinical presentation to warrant a repeat of the EMG study performed six months prior. Therefore, this request for electromyography (EMG) of the left lower extremity is not medically necessary.