

Case Number:	CM14-0159355		
Date Assigned:	10/03/2014	Date of Injury:	12/24/2010
Decision Date:	11/12/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/29/2014

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 Internal Medicine and is licensed to practice in New York. 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 70 year old male with a date of injury of 12/24/2010. He was pulling on a fender, fell backwards and injured his back. He was diagnosed with acquired spondylolithesis of L5 on S1. He was treated with physical therapy, medication, electrical stimulation, acupuncture (at least 24 visits), massage and hot packs. On 01/04/2011 he had low back pain radiating to his right lower extremity. He had chiropractic care and physical therapy in 2011. On 05/12/2011 he had a lumbar MRI that revealed multilevel disc bulges greatest at L4-L5 with moderately severe right foraminal stenosis and L5-S1 moderate right foraminal stenosis. He continued physical therapy and acupuncture for 4 weeks. On 06/07/2011 he continued acupuncture and physical therapy for another 4 weeks. On 06/10/2011 the lower extremity NCS was normal. EMG revealed a right lumbar radiculopathy at L5. Acupuncture was continued then on 07/26/2011. On 10/26/2011 he was prescribed Ultram, Prilosec and Zanaflex. In 10/2011 the EMG/NCS of both lower extremities was normal. On 11/07/2011 his low back pain and radiculopathy was 6-7/10. On 07/27/2012 he was taking Flexeril. He had acupuncture treatment from 12/19/2013 to 02/28/2014 (24 visits). On 01/31/2014 he was able to toe walk and heel walk. He had 7/10 low back pain that radiated to his right calf. There was decreased sensation of right L4 and L5. He was on no medications at that time but had been treated with Flexeril, NSAIDS and perhaps other medications. Straight leg raising was positive at the right. Flexeril, Ultram, Voltaren and Ambien were ordered. On 08/15/2014 he continued to have low back pain radiating to his right lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional acupuncture 1 x 12 for the low back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The patient has completed numerous courses of acupuncture treatment in 2011, 2012 and 24 visits from 12/2013 to 02/2014. According to acupuncture guidelines there must be objective documentation of functional improvement for continued acupuncture treatment. There was no documentation of any functional improvement with acupuncture. Continued acupuncture treatment is not consistent with the acupuncture guidelines. The request is not medically necessary.

Tramadol 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list Page(s): 76-80, 93-94, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78-80.

Decision rationale: Tramadol is an opioid. Chronic Pain Medical Treatment Guidelines, Opioids, page 78. 4) On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall

situation with regard to non-opioid means of pain control.(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. Since 01/2014 there is no documentation that the patient met the above criteria for on-going management with opioids. The request is not medically necessary.

Flexeril 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

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

Decision rationale: Chronic Pain Medical Treatment Guidelines, Muscle Relaxants (for pain) Page 63; recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include Chlorzoxazone, methocarbamol, Dantrolene and Baclofen. (Chou, 2004) According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See, 2008) Classifications: Muscle relaxants are a broad range of medications that are generally divided into antispasmodics, anti-spasticity drugs, and drugs with both actions. (See, 2008) (van Tulder, 2006). This patient has received long term (years) treatment with muscle relaxants (Flexeril and Zanaflex) and continued long term use is not consistent with MTUS guidelines. The request is not considered medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Ambien FDA approved package insert

Decision rationale: The MTUS and the ODG do not discuss Ambien. In ACOEM Chapter 12 Low Back complaints, Ambien is not mentioned as a recommended treatment. The patient was treated with Ambien in 01/2014 and had chronic treatment with Ambien for months. In the Ambien FDA approved package insert, the use of Ambien for more than 35 days is not documented to be safe and effective treatment. There were no clinical trials for FDA approval in which patients took Ambien for more than 35 days. Thus, this patient's long term use of Ambien is experimental and investigational treatment. It is not considered medically necessary.