MAXIMUS Federal Services

Case Number:	CM14-0024580		
Date Assigned:	06/11/2014	Date of Injury:	09/30/1992
Decision Date:	08/11/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/26/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 53-year-old female who reported an injury on 09/30/1992. The mechanism of injury was not provided for the clinical review. The diagnoses include status post lumbosacral spine fusion, lumbar sprain, lumbosacral radiculopathy/radiculitis, L4-5 and L5-S1 degenerative disc disease and status post anterior lumbar interbody fusion as well as hip pain. Previous treatments include surgery, medications, water therapy and ProStim. Within the clinical note dated 01/10/2014, it was reported that the injured worker complained of low back pain. The injured worker reported that the numbness and tingling had become worse in the bilateral lower extremities. She complained that the pain radiated down to the posterior aspect of the low back and wrapped primarily around the trochanteric region of the bilateral hips. Upon physical examination of the lumbar spine, the provider noted tenderness over the paraspinal musculature of the lumbar region on the right. Midline tenderness was noted in the lumbar spine. Flexion was at 30 degrees and extension at 10 degrees. The provider noted that spasms on lumbar range of motion were present with flexion. The provider indicated that the injured worker had a positive sciatic nerve compression test bilaterally. A trigger point injection was completed at the appointment into the low back. A urine drug screen was also completed at the appointment. The provider requested shockwave therapy, an EMG/NCV for radicular symptoms, a trigger point injection, Alprazolam for anxiety, Zolpidem, Cyclobenzaprine for muscle spasms and a urine drug screen to monitor for compliance. The Request for Authorization was not provided for the clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

UNKNOWN EXTRACORPOREAL SHOCK WAVE THERAPY TO THE BILATERAL HIPS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Shock Wave Therapy.

Decision rationale: The request for an unknown extracorporeal shockwave therapy to the bilateral hips is non-certified. The injured worker complained of low back pain. She reported that the numbness and tingling had progressively become worse in her lower extremities. She noted that the pain radiated down to the posterior aspect of the low back and wrapped primarily around the trochanteric region of the bilateral hips. The Official Disability Guidelines do not recommend the use of shockwave therapy. The available evidence does not support the effectiveness of ultrasound or shockwave for treating low back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. The request submitted does not specify duration of length that the provider is requesting treatment for. Additionally, the guidelines do not recommend the use of shockwave therapy. The guidelines note that there is no evidence to support the use for low back pain. Therefore, the request is non-certified.

UNKNOWN EXTRACORPOREAL SHOCK WAVE THERAPY TO THE LUMBAR SPINE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Shock Wave Therapy.

Decision rationale: The unknown extracorporeal shockwave therapy to the lumbar spine is non-certified. The injured worker complained of low back pain. She reported that the numbness and tingling had progressively become worse in her lower extremities. She noted that the pain radiated down to the posterior aspect of the low back and wrapped primarily around the trochanteric region of the bilateral hips. The Official Disability Guidelines do not recommend the use of shockwave therapy. The available evidence does not support the effectiveness of ultrasound or shockwave for treatment low back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. The request submitted failed to provide the length of duration that the provider is requesting the therapy for. Additionally, the guidelines do not support the use of shockwave therapy for treating low back pain. Therefore, the request is non-certified.

1 EMG STUDY OF 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 1 EMG of the lower extremity is non-certified. The injured worker complained of low back pain. She reported that the numbness and tingling had progressively become worse in her lower extremities. She noted that the pain radiated down to the posterior aspect of the low back and wrapped primarily around the trochanteric region of the bilateral hips. The California MTUS/ACOEM Guidelines note that electromyography, including H-reflex tests, may be useful to identify subtle, focal neurological dysfunction in injured workers with low back symptoms lasting more than 4 weeks. Discography is not recommended for assessing injured workers 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 documentation of the failure of conservative care. Therefore, the request is non-certified.

1 NCV STUDY OF LOWER EXTREMITIES: Upheld

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

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

Decision rationale: The request for 1 NCV study of the lower extremity is non-certified. The injured worker complained of low back pain. She reported that the numbness and tingling had progressively become worse in her lower extremities. She noted that the pain radiated down to the posterior aspect of the low back and wrapped primarily around the trochanteric region of the bilateral hips. The Official Disability Guidelines do not recommend nerve conduction studies as there is minimal justification for performing nerve conduction studies when the injured worker is presumed to have symptoms on the basis of radiculopathy. The clinical documentation submitted indicated that the injured worker complained of lower back pain with numbness and tingling radiating down to her low back and around her bilateral hips. Additionally, the guidelines do not support a nerve conduction study of the low back. Therefore, the request is non-certified.

1 TRIGGER POINT INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: The request for trigger point injections is non-certified. The injured worker complained of low back pain. She reported that the numbness and tingling had progressively become worse in her lower extremities. She noted that the pain radiated down to the posterior aspect of the low back and wrapped primarily around the trochanteric region of the bilateral hips. The California MTUS Guidelines recommend lumbar trigger point injections only for myofascial pain syndrome with limited lasting value, and they are not recommended for radicular pain. Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back pain or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) symptoms have persisted for more than 3 months; (3) medical management therapies, such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) radiculopathy is not present; (5) not more than 3 to 4 injections per session and (6) no repeat injections unless a greater than 50% pain relief is obtained for 6 weeks after an injection, and there is documented evidence of functional improvement. There is a lack of significant documentation indicating that medical management therapies, such as ongoing stretching, exercise, physical therapy, NSAIDs and muscle relaxants have failed to control pain. In addition, the clinical documentation submitted indicated that the injured worker complained of radiating pain. Therefore, the request is non-certified.

1 PRESCRIPTION OF ALPRAZOLAM XR 1MG #10: Upheld

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

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

Decision rationale: The request for 1 prescription of Alprazolam XR 1 mg #10 is non-certified. The injured worker complained of low back pain. She reported that the numbness and tingling had progressively become worse in her lower extremities. She noted that the pain radiated down to the posterior aspect of the low back and wrapped primarily around the trochanteric region of the bilateral hips. The California MTUS Guidelines do not recommend Alprazolam for long-term use due to the long-term efficacy being unproven and as there is a risk of dependence. The guidelines note to limit the use of Alprazolam to 4 weeks. The injured worker has been utilizing the medication for an extended period of time since at least 01/2014, which exceeds the guideline recommendations of short-term use of 4 weeks. There is a lack of clinical documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is non-certified.

1 PRESCRIPTION OF ZOLPIDEM 10MG #30: Upheld

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

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 request for 1 prescription of Zolpidem 10 mg #30 is non-certified. The injured worker complained of low back pain. She reported that the numbness and tingling had progressively become worse in her lower extremities. She noted that the pain radiated down to the posterior aspect of the low back and wrapped primarily around the trochanteric region of the bilateral hips. The Official Disability Guidelines note that Zolpidem is a prescription, short-acting, nonbenzodiazepine hypnotic which is approved for short-term use, usually 2 to 6 weeks, for the treatment of insomnia. The guidelines note that 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 then for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is a concern that they may increase pain and depression over long-term use. There was a lack of documentation indicating that the injured worker is treated for or diagnosed with insomnia. The injured worker has been utilizing the medication for an extended period of time, since at least 01/2014, which exceeds the guideline recommendations for short-term use for 2 to 6 weeks. 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. Therefore, the request is non-certified.

1 PRESCRIPTION OF CYCLOBENZAPRINE 7.5MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Cyclobenzaprine (Flexeril).

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

Decision rationale: The request for 1 prescription of Cyclobenzaprine 7.5 mg #60 is non-certified. The injured worker complained of low back pain. She reported that the numbness and tingling had progressively become worse in her lower extremities. She noted that the pain radiated down to the posterior aspect of the low back and wrapped primarily around the trochanteric region of the bilateral hips. The California MTUS Guidelines recommend nonsedating muscle relaxants with caution as a second-line option for the short-term treatment of acute exacerbations in injured workers with chronic low back pain. The guidelines note that the medication is not recommended to be used for longer than 2 to 3 weeks. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. There is no additional benefit shown in combination with NSAIDs. The efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. There was a lack of significant documentation indicating the efficacy of the medication, as evidenced

by a significant functional improvement. The request submitted failed to provide the frequency of the medication. The injured worker has utilized the medication for an extended period of time, since at least 01/2014, which exceeds the guideline recommendations of short-term use for 2 to 3 weeks. Therefore, the request is non-certified.

1 URINALYSIS DRUG SCREENING: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SUBSTANCE ABUSE, TOLERANCE, DEPENDENCE, ADDICTION, DRUG SCREENING.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Test Page(s): 43.

Decision rationale: The request for 1 urinalysis drug screen is non-certified. The injured worker complained of low back pain. She reported that the numbness and tingling had progressively become worse in her lower extremities. She noted that the pain radiated down to the posterior aspect of the low back and wrapped primarily around the trochanteric region of the bilateral hips. The California MTUS Guidelines recommend a urine drug test as an option to assess for the use or the presence of illegal drugs. They may also be used in conjunction with a therapeutic trial of opioids for ongoing management and as screening for risk of misuse and addiction. The documentation provided did not indicate that the injured worker displayed any aberrant behaviors, drug-seeking behaviors or whether the injured worker was suspected of illegal drug use. While a urine drug screen would be appropriate for individuals on opioids, the urine drug screen after the initial baseline would not be recommended unless there was significant documentation or aberrant drug-seeking behaviors. The injured worker had undergone a urine drug screen on 01/10/2014. Therefore, an additional urine drug screen would not be medically warranted at this time. As such, the request is non-certified.