

Case Number:	CM14-0070265		
Date Assigned:	07/14/2014	Date of Injury:	03/05/2014
Decision Date:	09/18/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/15/2014

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 Family 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:

This is a 49 year-old patient who reported an industrial injury on 3/5/2014, six months ago, attributed to the performance of usual and customary job tasks reported as being involved in a MVA. The patient claimed injuries to the shoulder, hand, middle finger, low back, neck, and ongoing headaches. The patient was noted to have selected a new PTP during April 2014 who reported that the patient complained of headaches, tinnitus, neck pain, tingling, shoulder pain, and pain, middle finger pain, low back pain, knee pain, GI distress, depression, stress, anxiety, and a lack of motivation. The patient was prescribed Norco, Cymbalta, and Topamax. The objective findings on examination included strength 5/5; cervical spine and lumbar spine tenderness to palpation; symmetrical reflexes; normal sensory examination, and normal gait. The diagnoses was cervical radiculopathy, lumbar radiculopathy, contusion of the face, scalp, and neck; closed fracture of the hand; and head injury. The patient was taken off work and placed on temporary disability. It was noted that the patient had MRIs and CT scan of the neck and head in the emergency room upon her initial evaluation on the date of injury. The patient was prescribed EMG/NCS of the bilateral lower extremities; MRI the cervical spine; MRI of the lumbar spine; Soma for muscle spasms; and Fioricet for headaches.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (Electromyography) of bilateral lower extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, EMG/NCS.

Decision rationale: There is no objective evidence of any changes in the neurological status of the patient to warrant electrodiagnostic studies. The patient was documented to have a normal neurological examination other than reported subjective lateral leg numbness. There was no objective finding on examination of a sensory loss over a dermatomal distribution. There is no evidence of a nerve impingement radiculopathy on the previously obtained MRI of the lumbar spine. The neurological examination was documented as normal. The patient continues to complain of back pain. There were no demonstrated neurological deficits along a dermatomal distribution to the BLEs that were reproducible on examination. The patient was not noted to have any changes in clinical status. The patient had some subjective complaints of radiculitis; however, there were no documented objective findings on examination to support medical necessity. There is no demonstrated medical necessity for a bilateral lower extremities EMG for the pain management of this patient. The request for the authorization of the EMG of the bilateral lower extremities was not supported with any objective clinical findings that would demonstrate a change in the neurological status of the patient or demonstrate neurological deficits in the lower extremities. The EMG was ordered to rule out pathology prior to the provision of a lumbar ESI; however, there was no rationale supported by objective evidence to support this rationale. There is no documented nerve impingement radiculopathy. There are no documented neurological findings that would suggest a nerve entrapment neuropathy in the clinical documentation to the bilateral lower extremities. The motor and sensory examination was documented to be normal. There is no demonstrated medical necessity of an EMG to the bilateral lower extremities.

NCS (Nerve Conduction Study) of bilateral lower extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Back Chapter, EMG/NCS.

Decision rationale: There is no objective evidence of any changes in the neurological status of the patient to warrant electrodiagnostic studies. The patient was documented to have a normal neurological examination other than reported subjective lateral leg numbness. There was no objective finding on examination of a sensory loss over a dermatomal distribution. There is no evidence of a nerve impingement radiculopathy on examination. The neurological examination was documented as normal. The patient continues to complain of back pain. There were no demonstrated neurological deficits along a dermatomal distribution to the BLEs that were reproducible on examination. The patient was not noted to have any changes in clinical status.

The patient had some subjective complaints of radiculitis; however, there were no documented objective findings on examination to support medical necessity. There is no demonstrated medical necessity for a bilateral lower extremities NCS for the pain management of this patient. The request for the authorization of the NCS of the bilateral lower extremities was not supported with any objective clinical findings that would demonstrate a change in the neurological status of the patient or demonstrate neurological deficits in the lower extremities. There is no documented nerve impingement radiculopathy. There are no documented neurological findings that would suggest a nerve entrapment neuropathy in the clinical documentation to the bilateral lower extremities. The motor and sensory examination was documented to be normal. There is no demonstrated medical necessity for the requested NCS of the bilateral lower extremities.

MRI, neck and low back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRI Lumbar Spine; Neck and Upper Back Chapter, MRI.

Decision rationale: The request for the authorization of a MRI of the lumbar/cervical spine for the diagnosis of lumbar/cervical spine pain was not supported with objective evidence on examination by the treating physician as there were no neurological deficits documented and no red flags documented for the reported pain to the back or neck which did not radiate to the lower extremities. The patient was noted to have had a prior MRI of the lumbar/cervical spine that documented only disc bulges. There was no evidence of changes in clinical status to warrant imaging studies of the lumbar/cervical spine. The request was not made with the contemplation of surgical intervention but as a screening study. The patient was noted to have had a MRI of the cervical spine in the emergency room. The patient was not noted to have objective findings documented consistent with a change in clinical status or neurological status to support the medical necessity of a MRI of the lumbar/cervical spine. The patient was documented to have subjective complaints of pain to the lower back with no documented objective findings to the Les or upper extremities. The patient reported persistent pain; however, there were no specified neurological deficits. There was no demonstrated medical necessity for a MRI of the lumbosacral spine based on the assessment by pain management. There are no documented progressive neurological changes as objective findings documented consistent with a lumbar/cervical radiculopathy as effects of the date of injury. There was no documented completion of the ongoing conservative treatment to the lower back and there is no specifically documented home exercise program for conditioning and strengthening. There are no demonstrated red flag diagnoses as recommended by the ODG or the ACOEM Guidelines. There is no demonstrated medical necessity for the requested repeated MRI of the lumbar/cervical spine.

Carisoprodol 350 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Muscle Relaxants and Carisoprodol.

Decision rationale: The patient is prescribed Carisoprodol/Soma 350 mg #60 on a routine basis for the treatment of chronic pain and is not directed to muscle spasms on an as needed basis. The CA MTUS does not recommend the prescription of Carisoprodol. There is no medical necessity for the prescribed Soma 350 mg #60 for chronic pain or muscle spasms as it is not recommended by evidence based guidelines. The prescription of Carisoprodol is not recommended by the CA MTUS for the treatment of injured workers. The prescription of Carisoprodol as a muscle relaxant is not demonstrated to be medically necessary for the treatment of the chronic back pain on a routine basis. The patient has been prescribed Carisoprodol on a routine basis for muscle spasms. There is no demonstrated medical necessity for the daily prescription of Carisoprodol as a muscle relaxer on a daily basis for chronic pain. The prescription of Carisoprodol for use of a muscle relaxant for cited chronic pain is inconsistent with the recommendations of the CA MTUS, the ACOEM Guidelines, and the Official Disability Guidelines. The use of alternative muscle relaxants was recommended by the CA MTUS and the Official Disability Guidelines for the short-term treatment of chronic pain with muscle spasms; however, muscle relaxants when used are for short-term use for acute pain and are not demonstrated to be effective in the treatment of chronic pain. The use of Carisoprodol is associated with abuse and significant side effects related to the psychotropic properties of the medication. The centrally acting effects are not limited to muscle relaxation. The prescription of Carisoprodol as a muscle relaxant that is not recommended as others muscle relaxants without psychotropic effects are readily available. There is no medical necessity for Carisoprodol 350 mg #60. There are clearly no recommendations for the prescribed combination of Valium and Carisoprodol due to the psychotropic effects. The California MTUS guidelines state that Carisoprodol is not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed centrally acting skeletal muscle relaxant whose primary active metabolite is Meprobamate a schedule for controlled substance. It has been suggested that the main effect is due to generalize sedation and treatment of anxiety. Abuses been noted for sedative and relaxant effects. In regular abusers, the main concern is for the accumulation of Meprobamate. Carisoprodol abuses also been noted in order to augment or alter effects of other drugs. This includes the following increasing sedation of benzodiazepines or alcohol; used to prevent side effects of cocaine; use with Tramadol to ghost relaxation and euphoria; as a combination with Hydrocodone as an effective some abuses claim is similar to heroin referred to as a Las Vegas cocktail; and as a combination with codeine referred to as Carisoprodol Coma. There is no documented functional improvement with the use of the prescribed Carisoprodol. The use of Carisoprodol/Soma is not recommended due to the well-known psychotropic properties. Therefore, this medication is not medically necessary.

Fioricet 50-300-40mg take as directed: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.PDR.NET.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306, Chronic Pain Treatment Guidelines Opioids Page(s): 74-97. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6, pages 114-116, Official Disability Guidelines (ODG), Pain Chapter, Opioids.

Decision rationale: The patient is prescribed Fioricet for reported headaches without a nexus to the cited mechanism of injury or the ongoing treatment of the patient. The patient has tension headaches, which can be treated readily with over the counter Excedrin in place of the prescribed Fioricet. The prescription for Fioricet is being continued as an opioid analgesic for the treatment of chronic pain when opioids are being prescribed beyond the recommended time period. There is no objective evidence provided of neuropathic pain. There is no objective evidence that the patient requires more than OTC analgesics for the various pain complaints. The patient has been prescribed generic Fioricet; however, the Butalbital in tablet is no longer recommended for treatment of headaches. The side effect profile of Butalbital has effectively reduced the use of this medication for headache pain. It is not currently recommended for "tension headaches." Many alternatives are readily available in the form of over-the-counter headache remedies. There is no objective evidence provided to support the medical necessity of Fioricet over the available OTC medications that also contains aspirin and caffeine. The patient could be taking Excedrin over the counter for similar relief. There is no objective evidence provided to support the continued prescription of Fioricet for headaches or for chronic shoulder pain. The patient is documented to have only tenderness to palpation on physical examination and there is no objective evidence to support more than over-the-counter analgesics for the treatment of this patient in relation to his reported headaches and residual post-operative shoulder pain. The chronic use of Fioricet is not recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic pain. The prescription of opiates on a continued long-term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain unless the pain is intractable. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain. Evidence-based guidelines necessitate documentation that the patient has signed an appropriate pain contract, functional expectations have been agreed to by the clinician, and the patient, pain medications will be provided by one physician only, and the patient agrees to use only those medications recommended or agreed to by the clinician to support the medical necessity of treatment with opioids. The ACOEM Guidelines updated chapter on chronic pain states "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect." There is no demonstrated medical necessity for the prescription of Fioricet directed to headaches.

