

Case Number:	CM14-0202790		
Date Assigned:	12/15/2014	Date of Injury:	09/13/2003
Decision Date:	02/05/2015	UR Denial Date:	11/11/2014
Priority:	Standard	Application Received:	12/03/2014

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 Practice 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 48-year old CNA/caregiver reported injuries to multiple body sites due to transferring a heavy patient on 9/13/03. Treatment has included 6 back surgeries with a fusion form L2-S1, a thumb surgery, a repair of an incisional abdominal hernia, multiple medications and physical therapy. The records reveal that she has been taking muscle relaxers since at least 2011, and opioids since at least 2009. She has not worked since her injury, and requires a home health aide for assistance with activities of daily living. A psychiatric Agreed Medical Evaluation performed 4/17/12 noted that the patient was taking opioids and sedative hypnotics and using cannabis daily. The examiner documented that he felt the patient was continually intoxicated and that it was dangerous for her to drive. His diagnoses included probable opiate and cannabis intoxication, and opiate-, cannabis- and sedative-induced mood disorder. The patient first saw her current primary treater on 1/21/14. At the time he documented that she was taking oxycodone, a muscle relaxer and Ambien (zolpidem). Treatment plan included continuing oxycodone, replacing Ambien with Restoril, starting Robaxin, refilling Lyrica, and requesting bilateral upper and lower extremity EMG/NCV (electromyography and nerve conduction velocities). A urine drug screen was collected at the same visit which was negative for oxycodone and zolpidem and positive for marijuana metabolites. There is a 2/5/14 report of a "review" of these results which appears to consist of multiple statements that have been cut and pasted, and which is essentially gibberish. It does not address the inconsistent negative or positive results of the test. The primary treater has prescribed Oxycodone at every subsequent visit. He has also prescribed a muscle relaxer and/or hypnotic, which varies from visit to visit and has included Lunesta, Ambien and Flexeril. Flexeril was prescribed as early as 4/22/14. Each visit includes a request for bilateral upper and lower extremity EMG/NCS, usually with the rationale that the studies are being requested to rule out chronic radiculopathy. In addition it

usually contains another incomprehensible, apparently cut and pasted rationale that reads "These have been citing radiculopathy on exam, but AME grades determines rating difference based on positive EMG, IE different category DRE'S". The record contains reports from bilateral upper and lower extremity EMG/NCS performed 9/16/14, apparently without authorization, which the primary treater never refers to. The record also contains MRI reports of the neck and upper back dated 2/20/14 which document diffuse degenerative changes with disc herniations at virtually all levels including C3-C7, T3-T12. A report of a lumbosacral MRI performed the same day notes fusion from L2-S1 without significant disc herniation. The most recent progress note in the records from the primary treater is dated 10/15/14. It documents ongoing severe neck pain radiating to both upper extremities, and low back pain radiating to both lower extremities. Exam findings include tenderness and decreased range of motion of the neck and back, decreased sensation in a left C6 distribution, positive bilateral straight leg raise, and weakness of the left extensor hallucis longus. Symptoms and findings regarding the right shoulder and left knee were also documented. Diagnoses include failed back surgery syndrome, multilevel cervicogenic disc disease, status post lumbar hernia repair, rule out right shoulder rotator cuff tear, and left knee sprain. Plan includes continuing oxycodone, discontinuing Ambien, and request for bilateral upper and lower extremity EMG/NCS with the same rationales as above. A request for authorization for oxycodone 30 mg #120, Flexeril 10 mg #90 and a referral to a knee specialist for left knee surgery was submitted on 10/31/14. On 11/11/14, the request for Oxycodone was modified in UR to #42 rather than #120, the request for Flexeril was non-certified, and the requests for bilateral upper and lower extremity EMG/NCS were non-certified, based on MTUS and ODG criteria, and on the fact that bilateral lower extremity EMG/NCS had already been performed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 30mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Criteria for use of Opioids; Opioids for neuropathic pain; Opioid.

Decision rationale: Oxycodone is an opioid analgesic. This patient is taking 120 mg of oxycodone per day, which is equivalent to 180 mg of morphine per day according to the Opioid dosing calculator cited above. According to the guidelines above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. Opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as

first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. The clinical findings in this case do not demonstrate that any of the above guidelines have been followed. There is no documentation that oxycodone was introduced individually, with ongoing careful assessment of function. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. Many of the documented symptoms and diagnoses make it appear that the patient's pain is neuropathic. Neuropathic pain does not necessarily respond well to opioids. The current treater made no assessment of whether or not opioid use was likely to be helpful in this patient, or of her potential for abuse. This patient has previous diagnoses of opiate and cannabis intoxication. She had a drug screen that was negative for oxycodone and for Ambien on a date that she was reported as taking these drugs. The negative drug screen should have raised concerns about drug diversion. This would be aberrant drug behavior and should have been addressed at once. No specific functional goals were set or followed. Oxycodone was not discontinued when it became clear that it has not produced any functional improvement. This patient remains profoundly disabled, and has been so for many years. Based on the MTUS Guidelines cited above and the clinical information provided for my review, Oxycodone 30 mg #120 is not medically necessary. It is not medically necessary because the patient may be actively engaging in aberrant drug behavior which has not been addressed, because no appropriate assessment of her current status was made, because no functional goals have been set or are being followed, and because the patient has exhibited no functional recovery as a result of taking oxycodone.

Flexeril 10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Muscle relaxants Page(s): 60; 63-66.

Decision rationale: Flexeril is brand-name cyclobenzaprine, which is a sedating muscle relaxant. Per the first reference cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Per the second reference, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In most low back pain patients, they show no benefit beyond that of NSAIDs. There is no additional benefit if they are used in combination with NSAIDs. Cyclobenzaprine is only recommended for a short course of therapy, as there is no evidence to support its long-term use. Its greatest effect appears to occur within the first four days of treatment. Side effects include drowsiness, urinary retention, dry mouth and headaches. Its use should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. The clinical documentation in this case does not support the use of cyclobenzaprine. Its prescription clearly extends beyond the four days that it is likely to be effective. Flexeril is sedating, particularly when combined with an opioid such as

oxycodone. It actually may make it more difficult for this patient to increase her level of activity and thus may be interfering with her recovery. Based on the MTUS citations above and on the clinical records provided for my review, cyclobenzaprine 10 mg #60 is not medically necessary in this case because there is no evidence to support its long-term use and because its side effects may in fact interfere with this patient's recovery.

EMG/NCV of bilateral upper and lower extremities to rule out chronic radiculopathy:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 13 Knee Complaints Page(s): 178 & 330. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 170,171,182, Chronic Pain Treatment Guidelines Page(s): 6,10. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Neck and Low Back chapters, Electrodiagnostic testing.

Decision rationale: EMG/NCV stands for electromyography/nerve conduction velocities, which are collectively known as neurodiagnostic testing. The MTUS Guidelines cited above state that a thorough history and physical exam are important to establish and confirm diagnoses and to understand and to observe and understand pain behavior. Diagnostic studies should be ordered in this context and simply for screening purposes. They also state that when a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment. Per the ACOEM neck and upper back chapter, patient evaluation should include neurological testing with focus on specific sensory, motor and reflex testing that may indicate specific nerve root dysfunction. Sensory testing should include light touch, pressure and pinprick sensations. EMG is recommended to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. : EMG not recommended for diagnosis of nerve root involvement if findings of history, physical exam and imaging sturdy are consistent for clinically obvious radiculopathy confirmed by imaging. Per the ODG references above, NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. The clinical documentation in this case does not support the performance of bilateral upper extremity EMG/NCS. The provider has already obtained and reviewed MRI's of the neck, upper back and lower back, which revealed diffuse degenerative changes and disc bulges. His documented exam findings are consistent with left C6 and left L4-5 radiculopathy. No diagnosis is being entertained that would require nerve velocity testing. No epidural steroid injections or spinal surgery is currently being contemplated. It is unclear that the performance of neurodiagnostic testing would result in a diagnosis not already obvious or which would result in a change of treatment plan. Based on the MTUS and ODG citations above and on the clinical documentation provided for my review, bilateral upper and lower extremity EMG/NCS to rule out chronic radiculopathy are not medically necessary. They are not medically necessary because the documentation makes it clear that the patient has chronic radiculopathy, because the

next appropriate studies, spinal MRI's, have already been performed, and because the provider does not appear to be planning epidural steroid injection or spinal surgery. In this case, electrodiagnostic testing would not serve any useful purpose.