

Case Number:	CM15-0145995		
Date Assigned:	08/06/2015	Date of Injury:	11/27/2007
Decision Date:	09/23/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 54 year old female, who sustained an industrial injury on 11-27-2007. Diagnoses include lumbago, cervicgia status post surgery, carpal tunnel syndrome and internal derangement knee NOS. Treatment to date has included surgical intervention as well as conservative measures including medications, transcutaneous electrical nerve stimulation (TENS) and injections. Per the Primary Treating Physician's Progress Report dated 4-28-2015, the injured worker reported frequent pain in the cervical spine with radiation to the upper extremities and constant pain in the lower back with radiation into the lower extremities. She also reports residual pain in the right shoulder blade and numbness of the bilateral upper extremities. Physical examination of the cervical spine revealed a well healing inclusion and no neurologic deficit. Examination of the lumbar spine revealed palpable paravertebral muscle tenderness with spasm. Seated nerve root test was positive and standing flexion and extension were guarded and restricted. The plan of care included medication management and diagnostics and authorization was requested for EMG (electromyography)/NCV (nerve conduction studies) of the left upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of the left upper extremities as outpatient: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 262.

Decision rationale: This patient presents with chronic neck pain that is improving and low back pain at 8/10 intensity. The request is for an EMG/NCV of the left upper extremities as outpatient. The UR letter is dated 6/23/15 and no RFA was provided. Examination of the C-spine showed no neurologic deficits. Lumbar spine showed tenderness, restricted ROM, no stability issues, but tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot, L5 and S1 patterns. X-ray of the C-spine showed ACDF or fusion at C4-6. ACOEM guidelines page 262 has the following regarding EMG/NCV for hand/wrist symptoms: Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. In this case, review of the reports do not show that this patient has had an EMG/NCV studies in the recent past. Comprehensive reports were not provided for this review and of the some 50 pages provided, there was no mention of a prior EMG/NCV studies. The patient is noted to have radiating pain into the left arm per 4/28/15 report. Given the support from ACOEM for electrical studies for rule out various disorders, the request IS medically necessary.

Lanzoprazole delayed release capsules Qty 120 refills not specified: 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): 69.

Decision rationale: This patient presents with chronic neck pain that is improving and low back pain at 8/10 intensity. The request is for Lanzoprazole delayed release capsules Qty 120 refills not specified. The UR letter is dated 6/23/15 and no RFA was provided. Examination of the C-spine showed no neurologic deficits. Lumbar spine showed tenderness, restricted ROM, no stability issues, but tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot, L5 and S1 patterns. X-ray of the C-spine showed ACDF or fusion at C4-6. Regarding medication use, there is a generic statement by the treater, "I am refilling the patient's medication today. The patient is to continue taking their medications as directed. They are helping in curing and relieving the patient's symptomatology..." No specifics are provided regarding this request. MTUS p69, NSAIDs, GI symptoms & cardiovascular risk (MTUS pg 69) Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. In this case,

no GI risk profile has been provided. There is no documentation of dyspepsia, GERD or PUD for which this medication would be indicated. The treater does not provide any specific documentation regarding this medication, why it is used, and with what effectiveness. The request IS NOT medically necessary.

Ondansetron 8mg ODT Qty 30 refills not specified: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter Pain, under Antiemetics (for opioid nausea).

Decision rationale: This patient presents with chronic neck pain that is improving and low back pain at 8/10 intensity. The request is for Ondansetron 8mg ODT Qty 30 refills not specified. The UR letter is dated 6/23/15 and no RFA was provided. Examination of the C-spine showed no neurologic deficits. Lumbar spine showed tenderness, restricted ROM, no stability issues, but tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot, L5 and S1 patterns. X-ray of the C-spine showed ACDF or fusion at C4-6. Regarding medication use, there is a generic statement by the treater, "I am refilling the patient's medication today. The patient is to continue taking their medications as directed. They are helping in curing and relieving the patient's symptomatology..." No specifics are provided regarding this request. ODG guidelines, Chapter Pain, under Antiemetics (for opioid nausea) not recommended for nausea and vomiting secondary to chronic opioid use. See Antiemetics Ondansetron (Zofran): This drug is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis. In this case, there is no documentation of chemotherapy/radiation treatment, and no nausea. There is no specific discussion as to why this medication is being prescribed. The request IS NOT medically necessary.

Cyclobenzaprine 7.5mg Qty 120 refills not specified: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available) Page(s): 64.

Decision rationale: This patient presents with chronic neck pain that is improving and low back pain at 8/10 intensity. The request is for Cyclobenzaprine 7.5mg Qty 120 refills not specified. The UR letter is dated 6/23/15 and no RFA was provided. Examination of the C-spine showed no neurologic deficits. Lumbar spine showed tenderness, restricted ROM, no stability issues, but tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot, L5 and S1 patterns. X-ray of the C-spine showed ACDF or fusion at C4-6. Regarding medication use, there is a generic statement by the treater, "I am refilling the patient's medication today. The patient is to continue taking their medications as directed. They are helping in curing and relieving the patient's symptomatology..." No specifics are provided regarding this request. MTUS pg 64, Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for

chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants. (e.g. amitriptyline) This medication is not recommended to be used for longer than 2-3 weeks. None of the reports specifically discuss this request. MTUS does not support long-term use of this medication. The current prescription is for #120, indicating longer than 2-3 weeks of its use. There is no documentation of a flare-up for which a short-term of this medication would be indicated. The request IS NOT medically necessary.

Tramadol ER 150mg Qty 90 refills not specified: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88, 89.

Decision rationale: This patient presents with chronic neck pain that is improving and low back pain at 8/10 intensity. The request is for Tramadol ER 150mg Qty 90 refills not specified. The UR letter is dated 6/23/15 and no RFA was provided. Examination of the C-spine showed no neurologic deficits. Lumbar spine showed tenderness, restricted ROM, no stability issues, but tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot, L5 and S1 patterns. X-ray of the C-spine showed ACDF or fusion at C4-6. Regarding medication use, there is a generic statement by the treater, "I am refilling the patient's medication today. The patient is to continue taking their medications as directed. They are helping in curing and relieving the patient's symptomatology..." No specifics are provided regarding this request. For chronic opiates use, MTUS guidelines p88, 89 Long-term users of opioids section require specific documentations regarding pain and function. Page 78 of MTUS require Pain Assessment that require 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. Furthermore, The 4 As for ongoing monitoring are required that include analgesia, ADLs, adverse side effects and aberrant drug-seeking behavior. In this case, the treater does not discuss the four A's. Only generic statement is provided on each of the notes. There is no before and after pain scale, no specific ADL changes showing significant difference. The treater does not indicate how this medication is being used with what effectiveness. No outcome measures are provided as required by MTUS. The request IS NOT medically necessary.

Sumatriptan Succinate 25mg Qty 18 refills not specified: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter Head, under Triptan.

Decision rationale: This patient presents with chronic neck pain that is improving and low back pain at 8/10 intensity. The request is for Sumatriptan Succinate 25mg Qty 18 refills not specified. The UR letter is dated 6/23/15 and no RFA was provided. Examination of the C-spine showed no neurologic deficits. Lumbar spine showed tenderness, restricted ROM, no stability issues, but tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot, L5 and S1 patterns. X-ray of the C-spine showed ACDF or fusion at C4-6. Regarding medication use,

there is a generic statement by the treater, "I am refilling the patient's medication today. The patient is to continue taking their medications as directed. They are helping in curing and relieving the patient's symptomatology..." No specifics are provided regarding this request. OGD guidelines Chapter Head, under Triptan: Recommended for migraine sufferers. At marketed doses, all oral triptans (e.g., sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients. A poor response to one triptan does not predict a poor response to other agents in that class. (Adelman, 2003) (Ashcroft, 2004) (Belsey, 2004) (Brandes 2005) (Diener, 2005) (Ferrari, 2003) (Gerth, 2001) (Mannix, 2005) (Martin 2005) (McCrary, 2003) (Moschiano, 2005) (Moskowitz, 1992) (Sheftell, 2005) Rizatriptan (Maxalt) has demonstrated, in a head-to-head study, higher response rates and a more rapid onset of action than sumatriptan, together with a favorable tolerability profile. Meta-analyses of double-blind placebo-controlled studies have confirmed the superior efficacy of rizatriptan. (Gbel, 2010) While the Maxalt brand of rizatriptan therapy is more expensive than other triptans, the economic value of rizatriptan depends on the payer's perspective, as the greatest savings can be expected to be achieved in terms of reduced migraine-related loss of work productivity compared with less effective treatments. (Mullins, 2007) (McCormack, 2005) According to the FDA Orange Book, equivalent generics have been approved for Maxalt, so generic rizatriptan would be recommended. (FDA, 2013) See also Migraine pharmaceutical treatment. While the treater describes "There are associated headaches that are migrainous in nature as well as tension between the shoulder blades," a diagnosis of migraines is not clearly provided. There is no discussion as to how this medication is used, how often the migraines attack, and how quickly the headache responds to this medication. There is no documentation of an aura, location of headaches, frequencies of attacks, etc. MTUS require documentation of pain and function when medications are used (p60). The request IS NOT medically necessary.