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| Case Number: | CM15-0188552 | | |
| Date Assigned: | 09/30/2015 | Date of Injury: | 10/11/2000 |
| Decision Date: | 12/01/2015 | UR Denial Date: | 09/23/2015 |
| Priority: | Standard | Application Received: | 09/24/2015 |

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: Tennessee, Florida, Ohio
 Certification(s)/Specialty: Surgery, Surgical Critical Care

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 injured worker is a 61 year old male who reported an industrial injury on 10-11-2000. His diagnoses, and or impressions, were noted to include: thoracolumbar spine sprain with left sacroiliac sprain and left leg radiculitis; and left lumbar disc protrusion with lumbosacral stenosis and multi-level bilateral facet hypertrophy. No current imaging studies were noted. A recent toxicology screening was noted on 3-20-2015. His treatments were noted to include: left lumbosacral epidural steroid injections (3-21-14) - 50-60% effective; magnetic resonance imaging studies of the lumbar spine (7-15-06 & 11-14-13); trans-cutaneous electrical stimulation unit therapy; a home exercise program; medication management with toxicology studies; and rest from work as he was noted to be retired. The progress notes of 8-31-2015 reported complaints which included: continued and unchanged low back pain, rated 7-9 out of 10, without appreciable radicular symptoms, that increased with movements and activities; and that he underwent additional chiropractic manipulative therapy (total of 6 sessions since return for re-evaluation on 3-2-2015, with reported benefit at low back of decreased pain and increased mobility, but that 1 week prior, he experienced a flare-up of low back with increased pain and decreased mobility; that he performed his home exercises including the stationary bike and used his trans-cutaneous electrical stimulation unit and ice applications Review of Symptoms noted positive complaints which included: weight gain; gastrointestinal complaints; joint pain, numbness and muscle spasms; and headaches. The objective findings were noted to include: tenderness of the lumbar spine, over the bilateral para-vertebral musculature and lumbosacral junction, with muscle guarding and spasms; a minimally positive sacroiliac stress test on the left;

straight leg raise test and extension-rotation maneuver elicited increased low back pain bilaterally; and limited lumbar spine range-of-motion. The physician's requests for treatment were noted to include 6 sessions of acupuncture, lumbar spine, for pain management, to facilitate activities of daily living, exercise, and address flare-up; and refills of Ultram 50 mg, Zanaflex 4 mg, and Ambien 10 mg; and for lumbar spine QuickDraw RAP to better stabilize lower back during periods of fatigue, and-or increased pain symptoms. The Request for Authorization, dated 8-31-2015, was noted to include: acupuncture treatment directed to the lumbar spine, at a frequency of 1 x per week, for 6 weeks, directed to the lumbar spine; lumbar spine QuickDraw RAP; Ultram 50 mg, 1 tablet twice per day as needed for pain, #60; Zanaflex 4 mg, 1-2 tablets every day as needed, #45; and Ambien 10 mg, 1 tablet at bedtime, #30. The Utilization Review of 9-23-2015 modified the request for 6 acupuncture treatments, to 3 treatments; Ultram 50 mg #60, to #54; Zanaflex 4 mg #45, to #40; and Ambien 10 mg #30, to #27; and non-certified the request for Lumbar Spine QuickDraw RAP (infinite use).

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture for the lumbar spine, quantity: 6: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a request for this patient. The clinical records submitted do not support prescription of a recommended frequency for this treatment. The California MTUS guidelines address the topic of prescriptions. Per the guidelines, there will be a limit of number of medications, and dose of specific medications. The medical records support that this patient has chronic back pain. However, the acupuncture prescription requested does not have a listed frequency for the requested treatments. Although a quantity (6) has been specified, there is no clear indication of the requested therapy's frequency (once a week, twice a week, etc). Therefore, based on the submitted medical documentation, the request for acupuncture is not medically necessary.

Lumbar spine QuickDraw RAP (infinite use), quantity: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM (American College of Occupational and Environmental Medicine) Web-based version: Low Back Complaints, Lumbar support (corset).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Follow-up Visits.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The Quickdraw RAP is a lumbar support brace. MTUS/ACOEM states Lumbar supports have not been shown to have any lasting benefit beyond

the acute phase of symptoms relief. The patient is beyond the acute phase of care, and the use of a lumbar support is not in accordance with MTUS/ACOEM guidelines for chronic pain. Therefore, based on the submitted medical documentation, the request for Medrol dose pack is not medically necessary.

Ultram 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. Per MTUS guidelines, Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Tramadol may increase the risk of seizure especially in patients taking SSRIs, TCAs and other opioids. Do not prescribe to patients that at risk for suicide or addiction. Per ODG, Tramadol is associated with an increased risk for hypoglycemia requiring hospitalization. Although rare, tramadol-induced hypoglycemia is a potentially fatal, adverse event. Hypoglycemia adds to mounting concerns about tramadol, a weak opioid that counter the perception that it is a safer alternative to full opioids. This patient has cervical pain which is currently being treated with opioids. The patient is at risk for addiction due to his current opioid use. Therefore, based on the submitted medical documentation, the request for tramadol is not medically necessary.

Zanaflex 4mg, #45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The MTUS Chronic Pain Medical Treatment Guidelines Section on Muscle Relaxants, states that regarding Tizanidine, it is for an unlabeled use for low back pain. The treatment guidelines do not support the use of Tizanidine as a first-line medication for this patient since the patient is noted to have had muscle twitches with need for chronic pain control. The medication is being used off-label without clear medical recommendation by the FDA or support in peer reviewed medical literature. Therefore, based on the submitted medical documentation, the request for Tizanidine is not 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 Official Disability Guidelines (ODG), Ambien.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Zolpidem.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of this medication. Per the Official Disability Guidelines (ODG), zolpidem is not recommended for long-term use. The clinical records submitted do support the fact that this patient has a remote history of insomnia. However, the records do not support the long-term use of this medication for that indication. Specifically, the patient's most recent clinical encounters do not document signs or symptoms of current insomnia. Therefore, based on the submitted medical documentation, the request for zolpidem is not medically necessary.