MAXIMUS Federal Services

Case Number:	CM14-0120005		
Date Assigned:	08/06/2014	Date of Injury:	09/10/2002
Decision Date:	09/30/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	07/30/2014

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:

Patient is a 61-year-old male who has submitted a claim for lumbar radiculopathy, right hip pain, bilateral knee pain, gastroesophageal reflux disease, insomnia, hypertension, and sciatica associated with an industrial injury date of 9/10/2002. Medical records from 2012 to 2014 were reviewed. Patient followed up status post removal of a lesion in the right shin performed on 4/17/2014. He reported persistent swelling and pain aggravated after prolonged activity. Patient likewise complained of low back pain radiating to the right lower extremity, aggravated by walking. Pain was rated 9/10 in severity, and relieved to 7/10 upon intake of medications. Opioid therapy allowed the patient to perform activities of daily living such as brushing teeth, cooking, and doing hobbies. Patient had symptoms of gastrointestinal upset. Patient likewise complained of insomnia secondary to chronic pain. Physical examination of the right knee showed swelling, mild quadriceps atrophy, tenderness and decreased sensation. Physical examination of the right hip showed weakness graded 4/5 and restricted range of motion. Examination of the lumbar spine showed restricted motion. Sensation was diminished at the right L5 dermatome. Straight leg raise test was positive at the right at 70 degrees. MRI of the lumbar spine, dated 11/1/2013, demonstrated 3 to 4-mm disc bulge at L4 to L5 with mild to moderate narrowing of the left lateral recess, and moderate narrowing of the left neural foramina. There were only mild right neural foramina narrowing. At L5 to S1, there was stable fusion without canal or significant foramina stenosis. Treatment to date has included lumbar fusion in 1997, epidural steroid injection at the right L4 to S1 on 06/05/2012 (resulting to 50% symptom relief for two months), hip replacement, knee replacement in April 2013, physical therapy, and medications such as Soma, Prilosec, Lisinopril, Ambien, and Norco (all since 2012), and Lidoderm patch (since June 2014). Utilization review from 7/22/2014 denied the request for Carisoprodol 350mg #90 because long-term use was not recommended; denied Zolpiderm 10mg #30 because there was no

documentation of improved sleep quality; denied Hydrocodone 10/325mg #180 because of no documented functional benefit from medication use; denied Lidoderm patch 5% #30 because there was no trial of first-line therapy; and Transforaminal Epidural Injection right L4, L5-S1 right-hip, lower back area, lumbar and/or sacral vertebra (vertebra NOC trunk)was considered medically necessary because patient presented with radiculopathy and corroborated by imaging findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodol 350mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Procedure Summary, and Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: As stated on page 29 of CA MTUS Chronic Pain Medical Treatment Guidelines, Carisoprodol (Soma) is a centrally acting skeletal muscle relaxant that is not indicated for long-term use. Carisoprodol abuse has been noted in order to augment or alter effects of other drugs such as Hydrocodone, Tramadol, Benzodiazepine, and Codeine. In this case, patient has been on Carisoprodol since 2012. However, long-term use is not recommended. The most recent physical examination likewise failed to show evidence of muscle spasm. Furthermore, this medication is being requested together with opioids, which is not recommended by the guidelines due to high potential of abuse. Therefore, the request for Carisoprodol 350mg #90 is not medically necessary.

Zolpiderm 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,Pain Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Chapter, Zolpidem section.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Pain Section was used instead. The Official Disability Guidelines state that Zolpidem (Ambien) is a prescription short-acting No benzodiazepine Hypnotic, which is approved for short-term usually 2-6 weeks treatment of insomnia. In this case, patient has been on Ambien since 2012 for insomnia. However, he has exceeded the guideline recommendation for the use of Ambien. Furthermore,

there was no discussion concerning sleep hygiene or sleep improvement with medication use. Therefore, the request for Zolpidem 10mg #30 is not medically necessary.

Hydrocodone 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on hydrocodone since 2012. Pain was rated 9/10 in severity, and relieved to 7/10 upon intake of medications. Opioid therapy likewise allowed the patient to perform activities of daily living such as brushing teeth, cooking, and doing hobbies. There is likewise no management response concerning this issue. Furthermore, urine drug screen tests were not made available for review. Guidelines criteria were not. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Hydrocodone 10/325mg #180 is not medically necessary.

Lidoderm patch 5% #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Patch Page(s): 56-57.

Decision rationale: Pages 56 to 57 of CA MTUS Chronic Pain Medical Treatment Guidelines state that topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). In this case, there was no prior use of Lidocaine patch. Clinical manifestations are consistent with neuropathy; however, there was no evidence of trial in first line therapy. Guideline criteria were not met. Therefore, the request for Lidoderm Patch 5% #30 is not medically necessary.

Transforaminal Epidural Injection Right L4, L5-S1 Right-Hip, Lower Back Area, Lumbar, and/or Sacral Vertebra (Vertebra NOC Trunk): 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 Epidural Steroid Injection Page(s): 46.

Decision rationale: As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. In this case, patient complained of low back pain radiating to the right lower extremity. Physical examination of the lumbar spine showed restricted motion. Sensation was diminished at the right L5 dermatome. Straight leg raise test was positive at the right at 70 degrees. Clinical manifestations are consistent with radiculopathy. Moreover, patient underwent Epidural Steroid Injection at the Right L4 to S1 on 06/05/2012 resulting to 50% symptom relief for two months. However, MRI of the lumbar spine from 11/1/2013, demonstrated 3 to 4-mm disc bulge at L4 to L5 with mild to moderate narrowing of the left lateral recess, and moderate narrowing of the left neural foramina. There were only mild right neural foramina narrowing. At L5 to S1, there was stable fusion without canal or significant foramina stenosis. There was no evidence of nerve root impingement or compromise to warrant ESI at intended levels for injection. Guideline criteria were not met. Therefore, the request for Transforaminal Epidural Injection right L4, L5-S1 right-hip, lower back area, lumbar and/or sacral vertebra (vertebra NOC trunk) is not medically necessary.