

Case Number:	CM14-0138623		
Date Assigned:	09/05/2014	Date of Injury:	09/13/2013
Decision Date:	09/26/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/27/2014

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 Orthopedic Surgery 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 49-year-old male sustained an industrial injury on 9/13/13. The mechanism of injury was not documented. The 10/11/13 lumbar spine MRI impression documented moderate to advanced L3/4 and L4/5 spondylosis and disc bulging with moderate to severe bilateral neuroforaminal stenosis. There was advanced L4/5 and moderate L5/S1 facet degeneration and hypertrophy. There was grade 1 spondylolisthesis at L5/S1 with mild to moderate bilateral neuroforaminal stenosis. The 7/10/14 treating physician report cited low back pain radiating to the left leg with weakness and left foot numbness and tingling. Physical exam documented mild antalgic gait. He was able to toe walk without difficulty but unable to heel walk due to left lower extremity pain. Thoracolumbar range of motion was moderately limited. Straight leg raise was equivocal. The diagnosis was myoligamentous strain of the lumbar spine with radicular symptoms to the left leg and MRI evidence of spondylosis, disc bulge, and neuroforaminal stenosis, L3/4 to L5/S1. The patient was working. The treatment plan requested authorization for surgical consult for the lumbar spine. Medications were dispensed including Omeprazole, Naproxen, Tizanidine, Tramadol, and Topical creams. The 7/15/14 bilateral lower extremity EMG/NCV findings were normal. The 7/22/14 AME report indicated there had been no significant change in his condition since last evaluation. The patient had just started physical therapy. The patient was taking multiple oral medications and using topical creams with no significant pain relief. Physical exam findings documented decreased and painful range of motion, decreased left outer foot sensation, and left ankle weakness consistent with neuropathy. The treatment plan recommended a course of oral steroids, continuation of current physical therapy, and referral for lumbar epidural steroid injections. The 8/14/14 utilization review denied the request for surgical consultation as there was no in-depth history of prior treatment rendered or outcomes or clinical exam evidence to support surgical referral. Bilateral lower extremity EMG/NCV was denied as there was no

documentation of neuromuscular disease or progressive neurologic deterioration. Ambien was denied as there was no documentation of a sleep disorder. Compound topical creams were denied as there was no guideline support for all components. Medications, including Prilosec, Naproxen, Ultram, and Zanaflex, were denied based on absence of documented indications or response consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgical consult for Lumbar Spine: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd ed. page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202.

Decision rationale: The California MTUS guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for treatment of a patient. Guideline criteria have been met. There is clinical evidence of neuropathy consistent with imaging. The patient has been unresponsive to conservative treatment to date. As the treatment plan may benefit from additional expertise, this request is medical necessity.

EMG/NCV studies BLE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, EMG (electromyography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309; 62-63.

Decision rationale: The California MTUS ACOEM guidelines state that EMG may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. EMG is not recommended for clinically obvious radiculopathy. Electrodiagnostic studies are recommended when imaging is equivocal and there are on-going pain complaints that raise questions about whether there may be a neurologic compromise. Guideline criteria have been met. On-going radicular pain complaints with numbness and tingling were documented suggestive of neurologic compromise with no clear imaging evidence of nerve root compression. Therefore, this request is medically necessary.

Ambien 5mg Qty 30 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Insomnia treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Zolpidem (Ambien®).

Decision rationale: The California Medical Treatment Utilization Schedule does not make recommendations relative to Ambien or insomnia treatment. The Official Disability Guidelines recommend the use of Ambien as first-line medication for the short term (two to six week) treatment of insomnia. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Guideline criteria have been met. There is no documentation of a sleep disturbance, duration of use of this medication, or response to this medication. The current prescription for 3 months of medication exceeds guideline recommendations. Therefore, this request is not medically necessary.

Topical cream (Flurbiprofen 20%, Lido 5%, Menthol 5%, Camphor 1%, Capsaicin .025% cream) 10gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113, 105.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: The California MTUS state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines indicate that topical analgesics in general are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical lidocaine is not recommended for non-neuropathic pain and only Lidocaine in the dermal patch formulation is recommended for neuropathic pain. Guidelines state there is little evidence to support the use of topical NSAIDs, such as Flurbiprofen, for treatment of osteoarthritis of the spine, and no evidence for treatment of neuropathic pain. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request is not medically necessary.

Topical cream (Tramadol 15%, dextromethorphan 10%, capsaicin .025%) 30mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113,105.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: The California MTUS state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical analgesics

are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is no evidence based medical support for the safety or efficacy of Tramadol used topically. Dextromethorphan is an NMDA-receptor antagonist like Ketamine. Ketamine is under study and only recommended for treatment of neuropathic pain in refractory cases where all primary and secondary treatment has been exhausted. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request is not medically necessary.

Prilosec 20mg Qty. 60: 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): 68-69.

Decision rationale: The California MTUS guidelines recommend the use of proton pump inhibitors (PPIs), such as Prilosec, for patients at risk for gastrointestinal events. Risk factors include age greater than 65 years, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). PPIs are reported highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Guideline criteria for intermediate gastrointestinal risk factors have not been met. There is no documentation of gastrointestinal symptoms or disease. Current medications do not meet guideline indications for PPI use. Therefore, this request is not medically necessary.

Naproxen 550mg Qty. 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-72.

Decision rationale: The California MTUS guidelines state non-steroidal anti-inflammatory drugs (NSAID), such as Naproxen, are indicated for short term lowest dosage treatment of symptoms associated with chronic back pain. Guidelines indicate that there is no evidence of long-term effectiveness for pain or function. Guideline criteria have not been met. Records indicate that the patient has not achieved significant pain relief with the use of this medication. There is no functional benefit documented. Continuation of use is not consistent with guidelines. Therefore, this request is not medically necessary.

Ultram 50mg Qty. 60: 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 Chapter, Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Tramadol Page(s): 76-80, 93-94, 113.

Decision rationale: The California MTUS indicate that opioid analgesics, such as Ultram, are recommended for moderate to moderately severe pain. In general, continued and long-term use of opioids is contingent upon a satisfactory response to treatment that may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Discontinuation is recommended if there is no overall improvement in function, unless there are extenuating circumstances. Guideline criteria have not been met for continued use. There is no documentation that the patient has achieved a satisfactory response to opioid therapy relative to decreased pain or increased function. In the absence of functional improvement, continued use is not supported by guidelines. This medication was dispensed, so weaning is not a consideration. Therefore, this request is not medically necessary.

Zanaflex 4mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Tizanidine (Zanaflex) Page(s): 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines indicate that Zanaflex is a muscle relaxant that is FDA approved for the management of spasticity. In generally, non-sedating muscle relaxants are recommended with caution as a second-line option for short term treatment of acute exacerbation in patients with chronic lower back pain. Guideline criteria have not been met. There is no current documentation of an acute exacerbation of this patient's chronic lower back pain. There is no clinical evidence of spasticity. Therefore, this request is not medically necessary.