

Case Number:	CM15-0119482		
Date Assigned:	06/29/2015	Date of Injury:	07/27/2013
Decision Date:	08/25/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/22/2015

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: New York
 Certification(s)/Specialty: Emergency Medicine

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 30-year-old male, who sustained an industrial injury on 07/27/2013. Some cement got into both of his work boots and he developed chemical burns in both legs. He developed 2nd and 3rd degrees burns. He began having motor control issues of the right lower extremity and had persistent weakness in the right lower extremity and difficulty ambulating. According to an agreed medical evaluation dated 01/15/2015, the injured worker was referred for evaluation of his bilateral lower extremities only. Medications noted under general medical history included Lyrica, Norco and Prilosec. He complained of constant moderate pain in his right hand, constant moderate low back pain, intermittent moderate right hip pain, constant moderate bilateral knee pain right greater than left with burning sensation and instability and moderate to severe right ankle pain with burning, numbness, instability and cramping radiating up the lower leg. He noted constant severe stomach upset, which had been present since he began taking Gabapentin in approximately August 2013. Review of records since injury listed medications that were prescribed and included lidocaine-epinephrine, Dilaudid, Zofran, antibiotics, Norco, Oxycontin, Gabapentin and Lyrica. On 01/21/2015, MRI of the lumbar spine performed on 01/21/2015 revealed a very large disc herniation measuring 7 millimeters in anterior posterior diameter at L3/4. While it was primarily left-sided, it does cause significant moderate to almost severe stenosis. According to a secondary treating physician's follow up orthopedic evaluation dated 03/25/2015, the injured worker complained of abdominal issues and had not been seen by a gastrointestinal specialist. He admitted to having insomnia, anxiety, depression and headaches. He complained of stomach discomfort due to medication. MRI of the

spine was reviewed. The provider noted that he had a disc bulge at L3-4 and that involvement of the L5 or S1 nerves was not seen. According to an intermediate consult dated 04/19/2015; the injured worker had more pain along the left lower part of his back and more numbness down the right leg. The turning and twisting of the right ankle had been somewhat stabilized by better shoes and time. He tried Lidoderm patches without benefit. Most of the pain was focused on the left side paraspinally. The provider requested authorization for Norco and Ambien. According to an intermediate consult dated 05/12/2015; the injured worker reported that he had difficulty with stability of his right ankle. He felt numbness from the knee downward. He had a burning sensation behind the knee. He also reported a vein that seemed to be prominent. He had ongoing gastrointestinal problems, which included intermittent bleeding rectum, cramping, problems with eating and reduced appetite. It was noted that another provider recommended that the injured worker see a gastrointestinal specialist. The injured worker was wearing a brace at the knee. Posteriorly in the knee, there was tenderness and a question of thrombosed vein without edema or evidence of any edema of the foot. His reflexes were 3 at the knees. The right ankle jerk was ½ and the left ankle jerk was 1. The provider recommended a second opinion from the spine surgeon to also include right knee evaluation and a consultation with a gastroenterologist due to ongoing gastrointestinal problems. Authorization was being requested for Norco 5-325mg one tablet twice d-day for pain management and for Ambien to assist him in sleeping. The provider noted that at this point in time, it was imperative that the injured worker has a final determination whether he is a spinal surgical candidate relative to lumbar spine or alternatively what recommendations would be made from orthopedic perspective. He was temporarily totally disabled over the next six weeks. Currently under review is the request for Norco 5/325mg #60, Ambien 5mg #50, second opinion spine surgeon and gastroenterology consult and treat.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76, 78.

Decision rationale: CA MTUS Guidelines list steps to take before a therapeutic trial of opioids and include an attempt to determine if the pain is nociceptive or neuropathic and if there are underlying contributing psychological issues. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain. Baseline pain and functional assessment should be made. Function should include social, physical, psychological, daily and work activities and should be performed using a validated instrument or numerical rating scale. Pain related assessment should include history of pain treatment and effect of pain and function. CA MTUS Chronic Pain Medical Treatment Guidelines state that the practitioner should perform ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Pain assessment should include current pain, the least reported pain over the period since the last assessment, average

pain, and the intensity of pain after taking the opioid, how long it takes for pain relief, how long pain relief lasts, improvement in pain and improvement in function. In this case, documentation shows past use of Norco by the injured worker. There was no objective evidence of functional improvement such as a return to work with previous use of Norco. It is unclear by documentation if Norco has been continued to be prescribed or if this is a new trial with Norco. Guidelines recommend before a trial of opioids begins, baseline pain and functional assessment should be made which was not done by the provider. If the request was for continued use of Norco, there was no discussion of the least reported pain over the period since the last assessment, average pain, and the intensity of pain after taking the opioid, how long it takes for pain relief, how long pain relief lasts, improvement in pain and improvement in function. As such, the request for Norco is not medically necessary.

Ambien 5mg #50: 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).

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

Decision rationale: CA MTUS Guidelines do not address Ambien (Zolpidem). Official Disability Guidelines (ODG) state that Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term (7-10 days) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. Cognitive behavioral therapy should be an important part of an insomnia treatment plan. ODG also recommends that treatment of insomnia be based on the etiology. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed and include sleep onset, sleep maintenance, sleep quality and next day functioning. In this case, authorization was requested for 50 Ambien, which exceeds recommended short-term use of 7-10 days. There was no discussion regarding sleep onset, sleep maintenance, and sleep quality and next-day functioning. There was no documentation of a sleep study or evaluation. The request for Ambien is not medically necessary.

Second opinion spine surgeon: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: On 3/25/2015, an orthopedic spine surgeon to review a lumbar spine MRI evaluated the IW. This study revealed an L4-L5 disc bulge with minimal stenosis. After a complete examination, the provider documented the reported symptoms and physical exam findings were not anatomically explained by the findings on the MRI. The provider, [REDACTED], documented a lengthy discussion with the IW regarding this. On 5/12/2015 the provider documented "...there were some issues as to whether a spine surgery could correct his conditions. As recalled, [REDACTED], a different orthopedic provider, recommended surgery." At this visit, the IW was reporting knee pain. There was a limited physical examination of the knee, but none of the spine documented at this visit. There is a request for a "second opinion from spine surgeon to also include right knee evaluations." The ACOEM states that referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. In this case, documentation supports the IW has been evaluated by 2 different spine surgeons and has had different recommendations. The request for this consult is for a spine surgeon, but also requests this provider evaluate the IW knee. It is unclear why the IW requires another spine surgeon evaluation. There is no spine examination documented at the time of the request for the referral. Without new or different patient symptoms or documented physical exam findings to support the need, a request for a second opinion spine surgeon is not medically necessary.

Gastroenterology Consult & Treat: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23-33.

Decision rationale: On 3/25/2015, the IW reported ongoing issues with discomfort due to medications. On 5/12/2015, a provider documents ongoing GI issues. This includes intermittent bleeding rectum, cramping, problems with eating and reduced appetite. The assessment of this visit sates a recommendation for "consultation with gastroenterologist relative to ongoing GI problems." There is no physical exam of the stomach documented at this visit. Review of the records does not include any documented abdominal examinations. There is no discussion of which medication is causing the abdominal issues or if different medications have been trialed. There is not enough information presented to show medical necessity for this referral. There is an insufficient accounting of the relevant signs and symptoms. The ACOEM Guidelines, pages 23-33, provide recommendations for evaluating medical conditions, including pertinent history and

physical findings. The treating physician has not provided an evaluation in accordance with this section of the MTUS. Medical necessity for any referral, test or treatment should be supportable from the available reports. Necessary information should include the relevant signs and symptoms, including the duration of symptoms, other relevant medical history, aggravating and relieving factors, and circumstances of onset. A basic physical exam should be included. In this case, this kind of information is not presented and the reason for this referral is unclear. For these reasons, the referral is not medical necessary.