

Case Number:	CM15-0178598		
Date Assigned:	09/18/2015	Date of Injury:	12/14/2009
Decision Date:	10/29/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/10/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 50-year-old male, who sustained an industrial injury on 12-14-09. The documentation on 8-24-15 noted that the injured worker has complaints of chronic low backache. The injured worker had complaints of moderate stiffness in his lower back with bilateral lower extremity paresthesias, left worse than the right. Left lower extremity he has burning pain radiating down the left lower extremity to the lateral aspect of his left foot, which is worse on stationary sitting and standing. He is unable to tolerate stationary sitting for more than 20 minutes. The pain did decrease with gabapentin and he noted better sleep and decreased burning sensation. The documentation noted that the injured worker has complaints of numbness over the medial border of the left hand including the fourth and fifth digits with loss of grip strength, which he states occurred following his surgery. Spine examination reveals loss of lumbar lordosis, on palpation there is bilateral lower lumbar paraspinal tenderness and 1+spam in the lower lumbar segment. Straight leg raise in the sitting position is 80 degrees. Magnetic resonance imaging (MRI) showed evidence of narrowing and scar tissue at the laminectomy site with impingement of the exiting nerve root. The diagnoses have included lumbar post laminectomy syndrome with left L5-S1 (sacroiliac) radiculitis; status post posterior spinal fusion; multilevel lumbar degenerative disc disease and left hand paresthesias likely secondary to cubital tunnel syndrome. Treatment to date has included Norco; Gabapentin; Flexeril; Miralax posterior spinal fusion in April of 2010; spinal injections; physical therapy and four-level spinal fusion in January of 2015. The documentation noted on 6-30-15 the injured worker had 12 sessions of physical therapy following his spinal surgery in January. The original utilization review (8-27-15) non-certified the request for electromyography and nerve conduction velocity study of the bilateral lower extremities and hydrocodone 10-325mg #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Per MTUS ACOEM p182, with regard to the detection of neurologic abnormalities, EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent, is not recommended. The documentation submitted for review indicates that the injured worker is status post laminectomy. MRI showed evidence of narrowing and scar tissue at the laminectomy site with impingement of the exiting nerve root. As the guidelines do not recommend EMG if the history, physical exam and imaging studies are consistent, the request is not medically necessary.

Hydrocodone 10/325mg #120: 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.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding ongoing management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. These domains have been summarized as the 4 A's (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking 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." Review of the available medical records reveals no documentation to support the medical necessity of hydrocodone nor any documentation addressing the '4 A's' domains, which is a recommended practice for the ongoing management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The

MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Furthermore, efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. There is no documentation comprehensively addressing this concern in the records available for my review. As MTUS recommends to discontinue opioids if there is no overall improvement in function, medical necessity cannot be affirmed. The request is not medically necessary.