

Case Number:	CM15-0034230		
Date Assigned:	02/27/2015	Date of Injury:	05/21/2014
Decision Date:	06/10/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/23/2015

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: Pediatrics, Internal 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 male, who sustained an industrial injury on 05/21/2014. On provider visit dated 01/08/2015 the injured worker has reported low back pain as well as burning sensation in his back, unable to sit or stand for a prolonged amount of time, neck strain and headaches. The diagnoses have included lumbar radiculopathy. Treatment to date has included medications. Treatment plan included refills of medication and chiropractic care to reduce the pain in his lumbar spine. On examination of lumbar spine he was noted to have spasm present and tenderness to palpation in the paraspinal muscles, restricted range of motion and positive straight leg raise. On 01/27/2015 Utilization Review non-certified chiropractic care 3 times a week for 4 weeks for the lumbar spine, Electromyogram (EMG) and Nerve Conduction Studies (NCS) of both lower extremities, Hydrocodone/Norco 5-325mg #60, Omeprazole DR 20mg #30 with 2 refills, and Orphenadrine ER 100mg #60 with 2 refills. The CA MTUS, ACOEM, Chronic Pain Medical Treatment Guidelines and ODG were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic care 3 times a week for 4 weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: Per MTUS, guidelines, manual therapy for the low back is recommended as an option. Therapeutic care, Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care is not medically necessary. Recurrences/flare-ups, Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. There is no documentation as to history of treatments received. The request exceeds the initial recommended trial length and thus is not medically necessary.

Electromyogram (EMG) and Nerve Conduction Studies (NCS) of both lower extremities:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: According to MTUS guidelines electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. MTUS does not have recommendations regarding NCS. ODG states that EMG is recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1- month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. ODG states that NCS is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Due to the request being for both studies it is not medically reasonable and necessary.

Hydrocodone/Norco 5-325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic).

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

Decision rationale: The Injured Worker is documented to be on a combination opioid for pain relief. Additionally, documentation did not include 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 last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary.

Omeprazole DR 20mg #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The indication for proton pump inhibitor use is intermediate or high risk of GI side effects. The risk factors include age > 65 years, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant and or high dose/multiple NSAID. There was no notation of GI symptoms or a history of risk factors. This request is not medically necessary or appropriate.

Orphenadrine ER 100mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Formulary.

Decision rationale: Per MTUS guidelines muscle relaxers are used to decrease muscle spasm in conditions such as LBP although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. ODG formulary states that orphenadrine is not a preferred agent and there are no records of a trial of a first line agent. This request is not medically necessary or appropriate.