

Case Number:	CM15-0038089		
Date Assigned:	03/06/2015	Date of Injury:	07/03/2013
Decision Date:	04/20/2015	UR Denial Date:	02/02/2015
Priority:	Standard	Application Received:	02/28/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 31 year old male, who sustained an industrial injury on 7/03/2013. The mechanism of injury was not noted. The diagnoses have included facet osteoarthropathy, bilateral L5 and S1. Treatment to date has included conservative measures. Currently, the injured worker complains of low back pain with radiculopathy symptoms to the left lower extremity, rated 7/10, and thoracic pain, rated 5/10. Physical exam noted tenderness in the lumbar spine and limited range of motion, notably with extension and rotation. Point tenderness was noted over the bilateral L5 facets. Spasm of the lumboparaspinal musculature was decreased. Diagnostics were not noted or referenced. On 2/02/2015, Utilization Review (UR) non-certified a request for acupuncture to the lumbar spine (2x6), electromyogram and nerve conduction studies, and Ambien 10mg #30. The UR modified a request for Hydrocodone 10mg #60 to #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2 x 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Acupuncture for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guideline Page(s): 13.

Decision rationale: The patient presents with low back pain with radiculopathy. The request is for ACUPUNCTURE 2 X 6 WEEKS. Physical examination to the thoracolumbar spine on 11/13/14 revealed tenderness to palpation in the interscapular and the lower lumbar area. Range of motion was decreased in all planes. Straight leg raising test was positive on the left at 45 degrees and on the right at 60 degrees. Patient's treatments have included ESIs, Tens unit and medication. Per 12/15/14 progress report, patient's diagnosis includes facet osteoarthropathy bilateral L5 and S1, rule out facet mediated low back pain, and thoracic myofascial pain. Patient's medications, per 12/15/14 progress report, include Hydrocodone, Naproxen, Pantoprazole, and Cyclobenzaprine. Per 12/15/14 progress report, patient is temporarily totally disabled for 4 weeks. 9792.24.1. Acupuncture Medical Treatment Guidelines. MTUS pg. 13 of 127 states: " (i) Time to produce functional improvement: 3 to 6 treatments (ii) Frequency: 1 to 3 times per week (iii) Optimum duration: 1 to 2 months. (D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e)." In this case, only two progress reports were provided. In 12/15/14 progress report, treater states that the patient has had no acupuncture to date. Given the patient's symptoms, a trial of acupuncture would be appropriate. However, the requested 12 sessions of acupuncture exceeds what is allowed by MTUS. Therefore, the request IS NOT medically necessary.

EMG/NCV bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, NCS.

Decision rationale: The patient presents with low back pain with radiculopathy. The request is stated for EMG/NCV LATERAL LOWER EXTREMITIES but it may be referring to bilateral extremities electrodiagnostics. Physical examination to the thoracolumbar spine on 11/13/14 revealed tenderness to palpation in the interscapular and the lower lumbar area. Range of motion was decreased in all planes. Straight leg raising test was positive on the left at 45 degrees and on the right at 60 degrees. Patient's treatments have included ESIs, Tens unit and medication. Per 12/15/14 progress report, patient's diagnosis includes facet osteoarthropathy bilateral L5 and S1, rule out facet mediated low back pain, and thoracic myofascial pain. Patient's medications, per 12/15/14 progress report, include Hydrocodone, Naproxen, Pantoprazole, and Cyclobenzaprine. Per 12/15/14 progress report, patient is temporarily totally disabled for 4 weeks. ACOEM guidelines page 303 states, "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." ODG guidelines do not support routine use of NCV when the leg symptoms are presumed to be coming from the spine. In this case, only two progress reports

were provided and both reports indicated patient was suffering from low back pain radiating into the left lower extremity. There is no documentation that prior electrodiagnostic studies have been done. Given that the patient has not had these tests performed in the past and the patient's continuing radiating symptoms in the left lower extremity, the request may be appropriate. However, the request is for bilateral leg studies, which is not needed as the patient has symptoms down the left leg. Furthermore, ODG does not support NCV studies when the leg symptoms are presumed to be coming from the spine. The treater does not raise any concerns for other issues such as plexopathies or peripheral neuropathies. Therefore, the request IS NOT medically necessary.

Hydrocodone 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Hydrocodone Page(s): 76-78, 88-89, 90.

Decision rationale: The patient presents with low back pain with radiculopathy. The request is for HYDROCODONE 10 MG # 60. Physical examination to the thoracolumbar spine on 11/13/14 revealed tenderness to palpation in the interscapular and the lower lumbar area. Range of motion was decreased in all planes. Straight leg raising test was positive on the left at 45 degrees and on the right at 60 degrees. Patient's treatments have included ESIs, Tens unit and medication. Per 12/15/14 progress report, patient's diagnosis includes facet osteoarthropathy bilateral L5 and S1, rule out facet mediated low back pain, and thoracic myofascial pain. Patient's medications, per 12/15/14 progress report, include Hydrocodone, Naproxen, Pantoprazole, and Cyclobenzaprine. Per 12/15/14 progress report, patient is temporarily totally disabled for 4 weeks. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs." In this case, only two progress reports were provided. The request is for Hydrocodone 10 mg # 60. The UR letter dated 02/02/15 has modified the request to #30. In review of the medical records provided, patient was prescribed Hydrocodone on 11/13/14 and 12/15/14. In progress report dated 12/15/14, treater states that Hydrocodone 10 mg does result in average four-five points decrease in pain on scale of 10. However, the 4A's are not appropriately addressed, as required by MTUS, there are no discussions regarding adverse side effects, aberrant behavior, etc. No UDS, CURES or opioid pain contracts were provided either. Given the lack of documentation as required by MTUS, the request IS NOT medically necessary.

Ambien 10mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain (Chronic) Chapter, Zolpidem (Ambien).

Decision rationale: The patient presents with low back pain with radiculopathy. The request is for AMBIEN 10 MG # 30. Physical examination to the thoracolumbar spine on 11/13/14 revealed tenderness to palpation in the interscapular and the lower lumbar area. Range of motion was decreased in all planes. Straight leg raising test was positive on the left at 45 degrees and on the right at 60 degrees. Patient's treatments have included ESIs, Tens unit and medication. Per 12/15/14 progress report, patient's diagnosis includes facet osteoarthopathy bilateral L5 and S1, rule out facet mediated low back pain, and thoracic myofascial pain. Patient's medications, per 12/15/14 progress report, include Hydrocodone, Naproxen, Pantoprazole, and Cyclobenzaprine. Per 12/15/14 progress report, patient is temporarily totally disabled for 4 weeks. ODG-TWC, Pain (Chronic) Chapter, Zolpidem (Ambien) Section states: "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. (Feinberg, 2008)" In this case, only two progress reports were provided. Treater has not provided a reason for the request. The request is for 30 tablets of Ambien 10 mg. In review of the medical records provided, there was no record of prior use of this medication. ODG recommends Ambien for short-term (7-10 days) treatment of insomnia, due to negative side effect profile. The request for quantity 30 does not indicate intended short-term use of this medication. The request is not in line with guideline indications. Therefore, the request IS NOT medically necessary.