

Case Number:	CM15-0048846		
Date Assigned:	04/07/2015	Date of Injury:	04/19/2008
Decision Date:	05/07/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	03/16/2015

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: Pennsylvania

Certification(s)/Specialty: 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 64 year old male who sustained an industrial injury on 4/19/08. He reported neck, low back and left wrist injury. The injured worker was diagnosed as having discogenic lumbar condition, discogenic cervical condition and elements of sleep disorder, stress and depression. Treatment to date has included back brace, transcutaneous electrical nerve stimulation (TENS) unit, hot/cold wrap, neck pillow, neck traction, use of a cane, lumbar spine facet block and radiofrequency ablation, physical therapy and home exercise program. Vicodin and MS contin were noted to be prescribed in 2012 and 2013. More recent progress notes document that Vicodin, MS contin, tramadol, Neurontin, and flexeril were prescribed since October 2014. At a visit on 2/5/15, the physician documented that electromyogram (EMG) of the lower extremities in 2009 and EMG of the upper extremities in 2012 was unremarkable. Magnetic resonance imaging of the cervical and lumbar spine in 2012 and of the cervical spine in 2014 showed disc protrusions with facet arthropathy. It was noted that the injured worker drinks occasionally. The injured worker reports shooting pain along the arms and legs with numbness and tingling along both upper and lower extremities. Upon physical exam dated 2/5/15, tenderness is noted along the cervical and lumbar paraspinal muscles bilaterally with decreased range of motion in the neck with positive facet loading. No neurological examination was documented. The physician documented that the injured worker retired in December 2010 and was not currently working. It was documented that the injured worker needs medication to be functional. The physician documented that a urine screen tested positive for marijuana and negative for MS contin, tramadol and Vicodin (prescribed medications). The treatment plan

consisted of (MRI) magnetic resonance imaging of lumbar spine, (EMG) Electromyogram of upper and lower extremities, TENS unit, Vicodin, MS Contin, Neurontin, Tramadol, Trazodone, Nalfon, Lunesta and Norflex and urine drug screen. An MRI of the lumbar spine on 1/13/15 showed multilevel foraminal stenosis and degenerative disease; this result was not discussed by the treating physician. On 3/10/15 Utilization Review (UR) non-certified requests for the services currently under Independent Medical Review, citing the MTUS, ACOEM, and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV bilateral upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): chapter 8 p. 168-171, 182, chapter 11 p. 268-269, 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter: EMG, nerve conduction studies.

Decision rationale: The ACOEM recommends EMG (electromyogram) to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. Nerve conduction velocity (NCV) is recommended for median or ulnar impingement at the wrist after failure of conservative treatment. The ODG notes that EMG is moderately sensitive in relation to cervical radiculopathy. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG does not clearly demonstrate radiculopathy or is clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. There are no reports from the prescribing physician which adequately describe neurologic findings that necessitate electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. This injured worker has had prior electrodiagnostic testing in 2012 that was described as unremarkable. No repeat testing would be indicated absent a significant clinical change as well as a discussion of those test results. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. Based on the current clinical information, electrodiagnostic testing of the upper

extremities is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

EMG/NCV bilateral lower extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter: EMGs (electromyography), nerve conduction studies.

Decision rationale: The ACOEM states that electromyography (EMG) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The ODG states that EMG may be useful to obtain unequivocal evidence of radiculopathy after one month of conservative therapy, but that EMGs are not necessary if radiculopathy is already clinically obvious. The ODG states that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. There are no reports from the prescribing physician which adequately describe neurologic findings that necessitate electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. This injured worker has had prior electrodiagnostic testing in 2009 that was described as unremarkable. No repeat testing would be indicated absent a significant clinical change as well as a discussion of those test results. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. Based on the current clinical information, electrodiagnostic testing of the lower extremities is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

Vicodin 5/300mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids, when to continue opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: This injured worker has been prescribed vicodin for more than two years. The treating physician has prescribed 2 short acting opiates together (vicodin and tramadol), which is redundant and not according to guidelines. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and

opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. Although the physician documented that the injured worker needs medications in order to be functional, there was no specific discussion of function. The injured worker was noted to be not working, retired since 2010. There was no discussion of activities of daily living. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. A recent urine drug screen was noted to be positive for marijuana and negative for the three opioids prescribed. These results were not addressed. MTUS also details indications for discontinuing opioid medication, such as serious non-adherence or diversion. The records clearly indicate inconsistent urine drug test and the inconsistent results are not explained by treating provider, which would be necessary for continued usage. Concurrent use of alcohol or other illicit drugs is considered adverse behavior. Immediate discontinuation of opioids has been suggested for use of illicit drugs and/or alcohol. The physician documented that the injured worker drinks occasionally, and the urine drug screen was positive for marijuana. As currently prescribed, Vicodin does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

MS Contin 15mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids, when to continue opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: This injured worker has been prescribed MS contin for more than two years. The treating physician has also prescribed 2 short acting opiates (vicodin and tramadol), which is redundant and not according to guidelines. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids

used to date. Although the physician documented that the injured worker needs medications in order to be functional, there was no specific discussion of function. The injured worker was noted to be not working, retired since 2010. There was no discussion of activities of daily living. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. A recent urine drug screen was noted to be positive for marijuana and negative for the three opioids prescribed. These results were not addressed. MTUS also details indications for discontinuing opioid medication, such as serious non-adherence or diversion. The records clearly indicate inconsistent urine drug test and the inconsistent results are not explained by treating provider, which would be necessary for continued usage. Concurrent use of alcohol or other illicit drugs is considered adverse behavior. Immediate discontinuation of opioids has been suggested for use of illicit drugs and/or alcohol. The physician documented that the injured worker drinks occasionally, and the urine drug screen was positive for marijuana. As currently prescribed, MS contin does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids, when to continue opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: Tramadol is a centrally acting synthetic opioid analgesic which is not recommended as a first line oral analgesic. Multiple side effects have been reported including increased risk of seizure especially in patients taking selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs) and other opioids. It may also produce life-threatening serotonin syndrome. This injured worker has been prescribed tramadol for at least three months. The treating physician has prescribed 2 short acting opiates together (vicodin and tramadol), which is redundant and not according to guidelines. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids

used to date. Although the physician documented that the injured worker needs medications in order to be functional, there was no specific discussion of function. The injured worker was noted to be not working, retired since 2010. There was no discussion of activities of daily living. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. A recent urine drug screen was noted to be positive for marijuana and negative for the three opioids prescribed. These results were not addressed. MTUS also details indications for discontinuing opioid medication, such as serious non-adherence or diversion. The records clearly indicate inconsistent urine drug test and the inconsistent results are not explained by treating provider, which would be necessary for continued usage. Concurrent use of alcohol or other illicit drugs is considered adverse behavior. Immediate discontinuation of opioids has been suggested for use of illicit drugs and/or alcohol. The physician documented that the injured worker drinks occasionally, and the urine drug screen was positive for marijuana. As currently prescribed, tramadol does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Lunesta 2mg #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 (ODG) chronic pain chapter: insomnia treatment.

Decision rationale: Lunesta (eszopiclone) is a nonbenzodizepine hypnotic agent indicated for the treatment of insomnia. The MTUS does not address the use of hypnotics other than benzodiazepines. No physician reports describe the specific criteria for a sleep disorder. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. For the treatment of insomnia, pharmacologic agents should only be used after careful evaluation of potential causes of sleep disturbance. Specific components of insomnia should be addressed. There was no documentation of evaluation of sleep disturbance in the injured worker, and components insomnia was not addressed. The treating physician has not addressed major issues affecting sleep in this patient, including the use of other psychoactive agents like opioids, which significantly impair sleep architecture, and depression. Lunesta is recommended for short term use; the quantity prescribed is not consistent with this. Due to lack of evaluation of sleep disturbance and quantity requested

not consistent with guideline recommendation for short term use, the request for lunesta is not medically necessary.

Norflex 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. This injured worker was prescribed flexeril, another muscle relaxant, for at least three months. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Orphenadrine (Norflex) is similar to diphenhydramine, but with greater anticholinergic effects; the mode of action is not clearly understood and effects are thought to be secondary to analgesic and anticholinergic properties. Side effects include drowsiness, urinary retention, and dry mouth; it has been reported in case studies to be abused for euphoria and to have mood elevating effects. Due to quantity requested in excess of the guideline recommendation for short term use, and lack of functional improvement as a result of prior use of muscle relaxants, the request for norflex is not medically necessary.

IF or muscle stimulator with conductive garment: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines interferential current stimulation Page(s): 118-120.

Decision rationale: Per the MTUS, interferential (IF) current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments including return to work, exercise, and medications. There are no standardized protocols for the use of interferential stimulation. If certain criteria are met, a one month trial may be appropriate to permit the physician and physical medicine provider to determine effects and benefits. Criteria include pain which is ineffectively controlled by medications, history of substance abuse, pain from postoperative conditions that limit the ability to perform exercise programs, or lack of response to conservative measures. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. The MTUS for Chronic Pain provides very limited support for interferential treatment, notes the poor quality

of medical evidence in support of interferential stimulation therapy, and states that there is insufficient evidence for using interferential stimulation for wound healing or soft tissue injury. The treating physician has not provided a treatment plan which includes interferential stimulation therapy in the context of the recommendations of the MTUS. This includes return to work, exercise, medications, and no conductive garment. The injured worker was noted to be retired and not working, and there was no discussion of any current exercise regime. This injured worker was previously treated with a TENS unit, but there was no documentation of a one month trial of IF stimulation. There was also no documentation that the injured worker cannot apply the stimulation pads alone or with the help of another available person, which would be necessary for the use of a conductive garment/jacket. Due to lack of treatment plan in accordance with the guidelines, the request for IF or muscle stimulator with conductive garment is not medically necessary.