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| Case Number: | CM15-0096954 | | |
| Date Assigned: | 05/27/2015 | Date of Injury: | 12/31/2014 |
| Decision Date: | 07/01/2015 | UR Denial Date: | 04/29/2015 |
| Priority: | Standard | Application Received: | 05/19/2015 |

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: Anesthesiology

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 36 year old male, who sustained an industrial injury on 12/31/2014. According to an initial complex orthopedic evaluation dated 04/21/2015, chief complaints included low back pain. Current pain level was 2-3 on a scale of 1-10. He had a recent flare up of his pain which he described as an electrical shock, pinching type pain into his lower back on 03/20/2015. He had improvement of pain with physical therapy and rest. Walking give him some relief as well. Current medications included Ibuprofen. Physical examination demonstrated gait and posture were within normal limits. Negative tenderness in the lower lumbar musculature and posterior superior iliac spine region were noted. Negative muscle spasms present. Motor testing was 5/5 to all muscle groups of the lower extremities. Walking on tiptoes was performed without difficulty. Walking on heels was performed without difficulty. Deep tendon reflexes were 2+ in the knee and ankle bilaterally. Range of motion of the lumbar spine demonstrated 60 degrees flexion, 30 degrees extension, rotation right and left 15 degrees and lateral bend right and left 30 degrees. Straight leg raise was negative bilaterally in the supine and sitting position. Neurovascular status was intact. Assessment included low back pain and radiculitis bilateral lower extremities. Treatment plan included MRI of the lumbar spine, EMG/nerve conduction studies, physical therapy, Sprix to relieve pain, pain management, Diclofenac XR for anti-inflammatory, Omeprazole for prophylaxis for chronic NSAID (nonsteroidal anti-inflammatory drug) use, Ondansetron to counter effect nausea from NSAIDS prophylaxis. Work restrictions included no heavy lifting, bending, stooping, crouching or crawling. Currently under review is the request for MRI of the lumbar spine, EMG/NCV of the

lower extremities, physical therapy x 18, pain management consultation, Diclofenac, Omeprazole and Ondansetron.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

Decision rationale: According to California MTUS Guidelines, MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication for an MRI of the lumbar spine. There are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no new neurologic findings on physical exam. Therefore, there is no specific indication for an MRI of the lumbar spine. Medical necessity for the requested MRI has not been established. The requested imaging study is not medically necessary.

EMG/NCV Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve Conduction Velocity Testing.

Decision rationale: The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle, focal neurologic dysfunction. The ODG further states that nerve conduction studies are recommended if the EMG is not clearly radiculopathy or 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. According to the ODG, EMG (Electromyography) and nerve conduction studies are an extension of the physical examination. They can be useful in adding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies, radiculopathies, and muscle disorders. According to ACOEM Guidelines, needle EMG and H-reflex tests to clarify nerve root dysfunction are recommended for the treatment of low back disorders. In this case, there is evidence of radiculopathy on exam. Medical necessity for the requested items has not been established, as guideline criteria have not been met. The requested items are not medically necessary.

Physical Therapy x18: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy: Lumbar Strain.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, the patient has completed three of six authorized physical therapy sessions. There is no documentation indicating that he requires the additional 18 requested PT sessions. Medical necessity for the requested PT sessions has not been established. The requested service is not medically necessary.

Pain Management Consultation: 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 ACOEM Practice Guidelines, page 127.

Decision rationale: According to the ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity of the requested pain management consultation for the lumbar spine. There is no evidence of radiculopathy or peripheral nerve entrapment. There is also no documentation that diagnostic and therapeutic management has been exhausted within the present treating provider's scope of practice. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Diclofenac: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: According to California MTUS Guidelines, oral NSAIDs, such as Diclofenac, are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), and short-term pain relief in chronic LBP. There is no evidence of long-term effectiveness for pain or function. According to the ODG, there is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain in this condition. Physicians should measure transaminases periodically in patients receiving long-term therapy with Diclofenac. In this case, it is unclear why the provider would request a 2nd NSAIDs, as documented to already be taking Ibuprofen. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

Omeprazole: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Prilosec has not been established. The requested medication is not medically necessary.

Ondansetron: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine.

Decision rationale: Ondansetron (Zofran) is used to prevent nausea and vomiting that may be caused by anesthesia/surgery, or chemotherapy or radiation therapy. It is also approved for use acutely with gastroenteritis. Ondansetron is not used and is ineffective for nausea associated with narcotic analgesics and NSAIDs. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.