

<b>Case Number:</b>	CM13-0021079		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	12/29/2001
<b>Decision Date:</b>	01/21/2014	<b>UR Denial Date:</b>	08/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/06/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 53-year-old male with a reported date of injury on 12/29/2001. The patient reported back and shoulder pain rated 9/10. The patient had tenderness upon palpation around the rotator cuff and under the acromion. The patient had crepitus with passive range of motion in the right shoulder, popping in the right shoulder, a positive right Neer's test, positive right Hawkins test, positive right Yergason's test, positive Speed's maneuver, moderate muscle pain in the lumbar area with bilateral tendon fibromuscular nodules, positive straight leg raise bilaterally at 70 degrees, a positive Braggard's on the right, a positive Kemp's test on the right, hypoalgesia in the L5-S1 dermatome, weakness in the foot extensors on the right and the gluteus medius on the right, and 0/4 patellar and Achilles deep tendon reflexes. The patient had a negative empty can test bilaterally, a negative left Neer's test, negative left Hawkins test, negative left Yergason's test, negative left Speed's maneuver, a negative left Braggard's, normal sensation in all dermatomes not listed above, and normal strength in all myotomes not listed above. The patient had diagnoses including right shoulder impingement syndrome, right shoulder adhesive capsulitis and tendinitis, lumbar discs at L4-5 and L5-S1 disc displacement, moderately severe muscle spasm in the lumbar region, chronic low back pain, facet syndrome in the lumbar region, mild right lumbar radiculopathy, and status post piriformis surgery. The physician's treatment plan included requests for Gabapentin 600mg, an Interferential Unit, Naproxen Sodium 550mg, Amitriptyline 50mg, 12 (Twelve) Chiropractic Manipulation Sessions, (12) Physical Therapy Sessions, Tramadol ER 150mg, a Transforaminal Epidural Injection at Right L4-5 and L5-S1, Tramadol APAP, and (1) One Steroid Injection to the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 600mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-22,49.

**Decision rationale:** The California MTUS guidelines note Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The guidelines recommend Gabapentin for patients with spinal cord injury as a trial for chronic neuropathic pain that is associated with this condition. The guidelines also recommend a trial of Gabapentin for patients with fibromyalgia and patients with lumbar spinal stenosis. The patient reported his current medications helped decrease his pain about 2 levels. Per the provided documentation, it did not appear the patient had a diagnosis of painful diabetic neuropathy or postherpetic neuralgia to demonstrate the patient's need for gabapentin. Additionally, the requesting physician did not include adequate documentation of significant objective functional improvement with the use of gabapentin. The request did not include the quantity of medication being requested. Therefore, the request for Gabapentin 600mg is neither medically necessary nor appropriate.

**An Interferential Unit: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118,120.

**Decision rationale:** The California MTUS guidelines note interferential 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, and limited evidence of improvement on those recommended treatments alone. The guidelines note it is possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: pain is ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. 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. Within the provided documentation, it was unclear if the patient had undergone a 1-month trial of an interferential unit with documentation of the efficacy and duration of the trial. Within the documentation, the provider noted the patient's TENS unit was no longer operational and therefore would need to be replaced; however, there was no documentation regarding the use of an interferential unit. Therefore, the request for an Interferential Unit is neither medically necessary nor appropriate.

**Naproxen Sodium 550mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

**Decision rationale:** The California MTUS guidelines recommend the use of NSAIDs for patients with osteoarthritis (including knee and hip) and patients with acute exacerbations of chronic low back pain. The guidelines recommended NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. In patients with acute exacerbations of chronic low back pain, the guidelines recommend NSAIDs as an option for short-term symptomatic relief. Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). Within the provided documentation, it did not appear the patient had a diagnosis of osteoarthritis. It appeared the patient had been utilizing naproxen since at least 06/2013. The guidelines recommend the use of naproxen for patients with acute exacerbations of chronic low back pain as an option for short-term symptomatic relief. It was unclear if the patient was experiencing an acute exacerbation of chronic low back pain. Additionally, it was unclear when the patient's CBC and chemistry profile had been monitored as the Guidelines recommend period lab monitoring. Additionally, within the provided documentation the requesting physician did not include adequate documentation of significant objective functional improvement with the use of the medication. Therefore, the request for Naproxen Sodium 550mg is neither medically necessary nor appropriate.

**Amitriptyline 50mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16.

**Decision rationale:** The California MTUS guidelines note antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or

contraindicated. The guidelines note antidepressants are recommended for patients with neuropathic pain as a first-line option, especially if pain is accompanied by insomnia, anxiety, or depression. The guidelines note antidepressants are recommended for patients with non-neuropathic pain as an option in depressed patients, but effectiveness is limited. Non-neuropathic pain is generally treated with analgesics and anti-inflammatories. Within the provided documentation, it did not appear the patient had a diagnosis of neuropathic pain. Within the provided documentation, the requesting physician did not include adequate documentation of significant objective functional improvement with the use of the medication. Therefore, the request for Amitriptyline 50mg is neither medically necessary nor appropriate.

**The request for twelve (12) chiropractic sessions:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

**Decision rationale:** The California MTUS guidelines note chiropractic treatment is recommended for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The guidelines note chiropractic care of the ankle & foot, for carpal tunnel syndrome, of the forearm, wrist, & hand, and of the knee are not recommended. The guidelines recommend up to 4-6 treatments in order to produce effect and with evidence of objective functional improvement up to a maximum of 8 weeks of treatment. The guidelines recommend a frequency of 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition and treatment may continue at 1 treatment per week for the next 6 weeks. Within the provided documentation, it was noted the patient attempted chiropractic care in the past, but it aggravated his neck and back pain so it was discontinued. It was unclear how many sessions of chiropractic care the patient had undergone in the past, and the efficacy was unclear. Additionally, the request for 12 sessions would exceed the guideline recommendation for total number of sessions as well as the guideline recommendation for a 6 visit clinical trial in order to demonstrate the efficacy of the chiropractic care. Therefore, the request for (12) Twelve Chiropractic Manipulation Sessions is neither medically necessary nor appropriate.

**The request for twelve (12) physical therapy sessions:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The California MTUS guidelines note 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The guidelines recommend 8-10 sessions of physical therapy over 4 weeks. The guidelines also recommend patients should undergo a 6 session trial of physical therapy followed by a complete assessment of the patient's condition in order to assess functional improvement before continuing therapy. Within the provided documentation, it was unclear how many sessions of physical therapy the patient has undergone in the past as well as the efficacy of the treatment. Additionally, the request for 12 sessions would exceed the guideline recommendation for total number of sessions as well as the guideline recommendation for a 6 visit clinical trial in order to demonstrate the efficacy of the therapy. Therefore, the request for (12) Physical Therapy Sessions is neither medically necessary nor appropriate.

**Tramadol ER 150mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**Decision rationale:** The California MTUS guidelines recommend patients utilizing opioid medication should obtain prescriptions from a single practitioner, medications should be taken as directed, and all prescriptions should come from a single pharmacy. The providers should prescribe the lowest possible dose should be prescribed to improve pain and function. Provider should conduct ongoing review with documentation of pain relief, functional status, appropriate medication use, and side effects. The 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. A satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Within the provided documentation, it was noted the patient's medications brought the patient's pain down 2 levels. However, the requesting physician did not include a full and adequate assessment of the patient's pain including current pain, the least reported pain over the period since the last assessment, average pain, intensity of the pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Within the provided documentation, there was no documentation of significant objective functional improvement with the use of the medication. Therefore, the request for Tramadol ER 150mg is neither medically necessary nor appropriate.

**A transforaminal epidural injection at right L4-5 & L5-S1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**Decision rationale:** The California MTUS guidelines note epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The guidelines note radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The patients should be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). The guidelines note no more than two nerve root levels should be injected using transforaminal blocks and no more than one interlaminar level should be injected at one session. Within the documentation, it was noted that the provider recommended physical therapy for the patient's back and radiculopathy and if the therapy was shown to be ineffective, the provider recommended epidural steroid injection. It was unclear if the patient had undergone any recent conservative care for the low back pain and radiculopathy as recommended by the provider; the efficacy of any recent conservative care was unclear. The patient underwent an MRI of the lumbar spine on 06/25/2012 which revealed a 3 mm broad right foraminal/lateral protrusion at the L4-5 level, which abutted the right exiting L4 nerve root, degenerative changes in the lumbar spine, indicating moderate to severe bilateral neural foraminal narrowing at L5-S1 level secondary to a 3 mm broad based posterior protrusion with associated annulated fissuring and hypertrophy of the facet joints, and broad based posterior protrusion contacting both exiting L5 nerve roots. The patient presented with decreased range of motion in the lumbar spine, a positive supine straight leg raise bilaterally at 70 degrees, hypoalgesia in the L5 and S1 dermatomes, and weakness in the right L4, L5, and S1 myotomes. Therefore, the request for a Transforaminal Epidural Injection at Right L4-5, L5-S1 is neither medically necessary nor appropriate.

**Tramadol APAP:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**Decision rationale:** The California MTUS guidelines recommend patients utilizing opioid medication should obtain prescriptions from a single practitioner, medications should be taken as directed, and all prescriptions should come from a single pharmacy. The providers should prescribe the lowest possible dose should be prescribed to improve pain and function. Provider should conduct ongoing review with documentation of pain relief, functional status, appropriate medication use, and side effects. The 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. A satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Within the provided

documentation, it was noted the patient's medications brought the patient's pain down 2 levels. However, the requesting physician did not include a full and adequate assessment of the patient's pain including current pain, the least reported pain over the period since the last assessment, average pain, intensity of the pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Within the provided documentation, there was no documentation of significant objective functional improvement with the use of the medication. Therefore, the request for Tramadol APAP is neither medically necessary nor appropriate.

**One steroid injection to the right shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

**Decision rationale:** The California MTUS guidelines do not address steroid injections of the shoulder. ACOEM states, invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. It was unclear if the patient had undergone any recent conservative care for the right shoulder. The duration and efficacy of any physical therapy undergone for the right shoulder was unclear within the provided documentation. Additionally, it was unclear if the patient had undergone any injections in the past as well as the efficacy of any injections received to the right shoulder. Therefore, the request for (1) One Steroid Injection to the right shoulder is neither medically necessary nor appropriate.