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| Case Number: | CM13-0049683 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 07/11/2012 |
| Decision Date: | 06/03/2014 | UR Denial Date: | 10/15/2013 |
| Priority: | Standard | Application Received: | 11/08/2013 |

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in 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 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/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 54 year old male injured on 07/11/12 due to repetitive work and heavy lifting resulting in pain to his neck, low back, right ankle, and bilateral wrists. The clinical documentation indicates the patient underwent MRI of the bilateral wrists and hands on 05/31/13; however, those results were not provided for review. Current diagnoses include lumbar radiculopathy; lumbar, cervical, ankle, wrist, and hand sprain/strain. The most recent clinical note dated 06/20/13 indicates the patient reported medications were helpful with pain in the lower back, right ankle, and bilateral wrists and neck. The patient rated her pain at 0/10 on VAS. Physical examination of the cervical spine revealed minimal decreased range of motion, pain, tenderness, and spasm noted about the bilateral paraspinal muscles and bilateral trapezius muscles upon palpation, Spurling's and cervical distraction tests were negative. Examination of the lumbar spine revealed moderate decreased range of motion, pain, tenderness, and spasm about the bilateral paraspinal muscles and bilateral lumbar spine muscles on palpation. There was a negative straight leg raise bilaterally, Braggart's test, iliac compression, Fortin finger sign, Patrick's, and Fabre's tests noted. Examination of the extremities revealed mild decreased range of motion at the bilateral wrists as well as pain and tenderness noted about the bilateral wrists, bilateral metacarpal phalangeal and interphalangeal joints. There was mild decreased range of motion as well as pain upon palpation at his right ankle. There was no muscle atrophy or edema noted. McMurray's and Apley's tests of the knee, and Cozen's tests of the elbow, and Tinel's and Phalen's tests were all negative. Sensory examination was intact to the upper and lower extremities, motor examination revealed 5/5 strength in all muscle groups bilaterally, and reflexes were equal and symmetric bilaterally in the upper and lower extremities upon examination. Current medications were listed as Ultracet ER, Prilosec 20mg, Norco 10/325mg, and Soma 350mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG OF BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ACOEM OCCUPATIONAL MEDICINE PRACTICE GUIDELINES 2ND EDITION 2004, LOW BACK COMPLAINTS, PAGES 308-310.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM) 2ND EDITION, (2004), LOW BACK DISORDERS, ELECTROMYOGRAPHY-ONLINE VERSION.

Decision rationale: As noted in the Low Back Disorders chapter of the American College of Occupational and Environmental Medicine Electrodiagnostic studies are not recommended for patients with acute, subacute, or chronic back pain who do not have significant lower extremity pain or numbness. The clinical documentation failed to establish the presence of objective or subjective findings consistent with paresthesias. As such, the request for EMG of bilateral lower extremities cannot be recommended as medically necessary at this time.

EMG OF BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM) 2ND EDITION, (2004), HAND, WRIST AND FOREARM DISORDERS, ELECTRODIAGNOSTIC STUDIES - ONLINE VERSION.

Decision rationale: As noted in the Hand, Wrist and Forearm Disorders chapter of the American College of Occupational and Environmental Medicine, electrodiagnostic studies are recommended to evaluate non-specific hand, wrist, or forearm pain for patients with paresthesias or other neurological symptoms. The clinical documentation failed to establish the presence of objective or subjective findings consistent with paresthesias. As such, the request for EMG of bilateral upper extremities cannot be recommended as medically necessary at this time.

TRAMADOL ER (ULTRACET ER): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Page(s): 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria For Use, Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. The clinical notes indicate that the current medication regimen has is helpful in managing her pain. The patient rated her pain at 0/10 on VAS and indicated substantial pain relief. As the clinical documentation provided for review supports an appropriate evaluation for the continued use of narcotics as well as establishes the efficacy of narcotics, the request for tramadol ER (Ultracet ER) is recommended as medically necessary.

GENICIN #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (And Chondroitin Sulfate), Page(s): 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (And Chondroitin Sulfate), Page(s): 48.

Decision rationale: As noted on page 48 of the Chronic Pain Medical Treatment Guidelines, Glucosamine is ecommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. The clincal documentation does not indicate that the patient complains of knee pain. As such, the request for Genicin #90 cannot be recommended as medically necessary.

SOMA 350MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma), Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol, Page(s): 65.

Decision rationale: As noted on page 65 of the Chronic Pain Medical Treatment Guidelines, Soma is recommended for no longer than a 2 to 3 week period. The documentation indicates the patient has been prescribed the medication for long-term use. As such, the request for Soma 350mg cannot be recommended as medically necessary at this time.

ALPRAZOLAM 0.5MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, Page(s): 24.

Decision rationale: As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. The patient has exceeded the 4 week treatment window. As such, the request for alprazolam 0.5mg cannot be recommended at this time.

TEROCIN 240ML #2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111.

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Therefore, Terocin 240mL cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

MRI OF C/S (CERVICAL SPINE): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

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

Decision rationale: As noted in the American College of Occupational and Environmental Medicine guidelines, MRI is recommended for patients with acute cervical pain with progressive neurologic deficit; significant trauma with no improvement in significantly painful or debilitating symptoms; history of neoplasia (cancer); multiple neurological abnormalities that span more than one neurological root level; previous neck surgery with increasing neurologic symptoms; fever with severe cervical pain; or symptoms or signs of myelopathy. The patient does not meet any of these criteria. As such, the request cannot be recommended as medically necessary at this time.

CONTINUED CHIROPRACTIC TREATMENT: 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): 59.

Decision rationale: As noted on page 59 of the Chronic Pain Medical Treatment Guidelines, Chiropractic care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered maximum may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. The number of previous treatments and extent of functional improvement was not provided for review. As such, the request for continued chiropractic treatment cannot be recommended as medically necessary at this time.

CONTINUED ACUPUNCTURE: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: As noted in the Acupuncture Medical Treatment Guidelines, frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows time to produce functional improvement: 3 to 6 treatments; frequency: 1 to 3 times per week; optimum duration: 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. There is no documentation to indication the number of previous acupuncture treatments or function improvement. As such, the request for continued acupuncture cannot be recommended as medically necessary at this time.

SOMNICIN #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN (CHRONIC), MEDICAL FOOD.

Decision rationale: As noted in the Official Disability Guidelines - Online version medical foods class, Somnicin is not indicated as one of the ODG approved medical foods for administration. Additionally, the documentation does not indicate that the patient requires treatment for sleep disorder. As such, the request for Somnicin #30 cannot be recommended as medically necessary.

OMEPRAZOLE 20MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk..

Decision rationale: Proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. Risk factors for gastrointestinal events include age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no indication that the patient is at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. As such, the request for omeprazole 20mg cannot be established as medically necessary.

MRI OF L/S: 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.

Decision rationale: MRI is recommended as an option for the evaluation of select chronic LBP patients in order to rule out concurrent pathology unrelated to injury. This option should not be considered before 3 months and only after other treatment modalities (including NSAIDs, aerobic exercise, other exercise, and considerations for manipulation and acupuncture) have failed. There is no indication that the patient has underlying pathology that is unrelated to the original injury. As such, the request cannot be recommended as medically necessary at this time.

MRI OF RIGHT ANKLE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 1043.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

Decision rationale: MRI of the ankle is recommended for patients who have no limited improvement with non-operative therapy after 4 to 6 weeks, persistent pain with weight bearing, or chronic feeling of instability; ankle injuries that involve crepitus, catching or locking, as these symptoms may be associated with a displaced osteochondral fragment. There are no subjective or objective findings that substantiate the requirements for MRI of the ankle.

MRI OF BILATERAL WRISTS AND HANDS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: The clinical documentation indicates a MRI of the bilateral wrists and hands was performed on May 31, 2013. As such, the request for a second MRI cannot be recommended as medically necessary this time.