MAXIMUS Federal Services

Case Number:	CM13-0052215		
Date Assigned:	12/27/2013	Date of Injury:	11/30/2010
Decision Date:	07/10/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	11/15/2013

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 and Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 52-year-old female who reported an injury on 11/30/2010; the mechanism of injury was reported as a lifting injury. Within the clinical note dated 10/09/2013, the injured worker reported headaches and neck pain that radiated to the upper extremities with associated numbness and tingling on the left side of the face. The injured worker reported that the pain was rated at a 7/10 and further complained of frequent low back pain rated at an 8/10 with radiation to the left lower extremity as well as numbness and tingling. The injured worker further reported constipation. In regards to her acupuncture therapy, the worker reported that it relieved the pain by more than 50%. The medications reported within the notes included Soma, Oxycodone 15 mg and Relafen; however, the dosages and frequencies were not fully given. The injured worker stated that the medication relieved 20% of the pain. The physical exam reported that the injured worker was attending physical therapy 2 times a week and had completed 1 chiropractic session. Sensory exam revealed diminished sensation over the right C5 and C6 dermatomes and the left C7 dermatome. Strength of the upper right extremity revealed a 4/5. The listed diagnoses include cervical spine radiculopathy, lumbar spine radiculopathy, chronic pain syndrome, chronic low back pain and neuropathic pain. An official MRI dated 10/05/2013, read by [redacted], revealed that at levels C5-7, there was a broad-based disc protrusion with mild neural foraminal stenosis. The Request for Authorization was dated 10/09/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS FOR THE CERVICAL SPINE, LUMBAR SPINE AND LEFT KNEE AND TRIAL OF TRACTION: Upheld

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

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

Decision rationale: The request for physical therapy two (2) times a week for four weeks for the cervical spine, lumbar spine and left knee and s trial of traction is not medically necessary. The California MTUS Guidelines recommend physical therapy for neuralgia, neuritis, and radiculitis for 8 to 10 visits over 4 weeks in the presence of a functional deficit and can provide short-term relief during the early phases of treatment. The injured worker did have documentation that showed past physical therapy had been completed; however, the quantity of sessions was not documented. Furthermore, there was a lack of documentation of if the injured worker had objective functional gains. Lastly, without knowing the number of total physical therapy sessions completed, it is unknown if the request has exceeded the guidelines' parameters and the presence of any extenuating circumstances or exacerbations of acute change of condition. Hence, the request is not medically necessary.

ACUPUNCTURE TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS FOR THE CERVICAL SPINE, LUMBAR SPINE AND LEFT KNEE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture 2 times a week for 4 weeks for the cervical spine, lumbar spine and left knee is not medically necessary. The California MTUS Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The guidelines further state that the time to produce functional improvement should be seen within 3 to 6 treatments with a frequency of 1 to 3 times a week for an ultimate duration of 1 to 2 months. The submitted medical records do not state the number of actual acupuncture sessions that the injured worker had completed. Furthermore, there was no documentation that stated that there was going to be a reduction in the amount of pain medication utilized; and within the last clinical note, the same dosage was prescribed. Additionally, there was no mention of a surgical procedure or documentation of functional gains from the previous acupuncture sessions. Without knowing the functional gains from the previous acupuncture sessions to determine if the injured worker has exceeded the parameters set forth by the guidelines and a documentation of the functional gains from the previous sessions, the request cannot be supported by the guidelines. As such, the request is not medically necessary.

EPIDURAL STEROID INJECTION AT C6-7: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Epidural Steroid Injections.

Decision rationale: The request for an epidural steroid injection at C6-7 is not medically necessary. The Official Disability Guidelines state that epidural steroid injections are recommended as an option for the treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). The guidelines have further set forth criteria for the use of epidural steroid injections. First, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Secondly, the injured worker must initially be unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Lastly, the guidelines state that injections should be performed using fluoroscopy for guidance. With the clinical notes, the injured worker reported that she was receiving more than 50% pain reduction from acupuncture, 20% relief from pharmaceutical interventions and at the same time attending physical therapy 2 times a week with chiropractic treatment. However, within the clinical notes, it was not revealed as to whether or not the physical therapy had failed and if there were functional gains from other therapies. Additionally, the request does not include fluoroscopic guidance as recommended by the guidelines. Without knowing the outcomes of the physical therapy or additional therapies and whether the injections will be under fluoroscopic guidance, the request is not supported by the guidelines. As such, the request is not medically necessary.

ORUDIS (KETOPROFEN 75MG) #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-72.

Decision rationale: The request for Orudis (ketoprofen 75 mg) #90 is not medically necessary. The California MTUS Guidelines recommend an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The guidelines further recommend that NSAIDs be utilized at the lowest dose for the shortest period in patients with moderate to severe pain. The guidelines further state that given the large range of adverse effects of NSAIDs, acetaminophen may be considered for initial therapy for patients with mild to moderate pain. Given that the injured worker has utilized this medication for a substantial amount of time, it is contraindicated by the guidelines' recommended usage for short-term periods and there was not a documented trial to utilize the lowest dose possible. In addition, the

documentation lacks an assessment of functional gains from utilizing the medication. As such, the request is not medically necessary.

OXYCODONE 30MG #60: Upheld

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

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

Decision rationale: The request for Hydrocodone/APAP 10/325mg is not medically necessary. The California MTUS Guidelines recognize four domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. There is a lack of documentation as to why the urine drug screens were not consistent with medications prescribed at the time and would indicate misuse and/or abuse. This would include the lack of prescribed medications in the drug screen and not have a documented discussion as to why they were not present and the appearance of controlled substances that were not prescribed. In addition, within the clinical notes, the injured worker has reported high pain ratings, and the limited pain assessments did not indicate whether the pain ratings were done with or without medication. Lastly, the injured worker did not show any objective signs of functional improvement while on the medication. Hence, the request is not medically necessary.

SOMA #90: Upheld

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

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

Decision rationale: The request for Soma 350 mg is not medically necessary. The California MTUS Guidelines do not recommend Soma and is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate. The injured worker has documented prolonged utilization of Soma, which is not recommended by the guidelines. Given the guidelines do not overall recommend the utilization of Soma and the prolonged documented utilization of Soma the request is not supported by the guidelines. Hence, the request is not medically necessary.