

Case Number:	CM13-0063097		
Date Assigned:	12/30/2013	Date of Injury:	05/26/1991
Decision Date:	04/30/2014	UR Denial Date:	11/18/2012
Priority:	Standard	Application Received:	12/09/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 63-year-old female who reported an injury on 05/26/1991. The mechanism of injury was not provided. The patient's current diagnosis includes tear of the meniscus. The patient's medication history included Provigil, Protonix, NSAIDS, opiates, and benzodiazepines as of 03/2013 and there was Lidoderm per documentation as of 05/2013. The patient was noted to have completed 8 chiropractic treatments. The patient had 60% overall improvement with less pain and less frequency. The patient said that they had an increased ability to do ADLs and home exercises. Additionally, it was noted the patient has an improvement in active range of motion. The documentation of 12/10/2013 revealed the patient had pool therapy and chiropractic adjustments which were helpful for pain. The patient was using Nucynta for pain control and as of the date 12/10/2013 the patient asked to return to OxyContin. The patient's diagnoses included post laminectomy pain syndrome with chronic lumbar radiculitis, status post failed spinal cord stimulator, multilevel cervical spondylosis, right knee meniscal tear, chronic pain syndrome, narcotic dependency, left piriformis syndrome, left trochanteric bursitis, fibromyalgia and severe hypertension. The treatment plan included the patient had requested additional pool therapy and they were awaiting authorization for 8 sessions, the patient was awaiting authorization for right Synvisc injections, the request was made for a yearly gym membership and medication refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL CHIROPRACTIC VISITS X 7 FOR THE CERVICAL AND LUMBAR SPINES: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy, Page(s): 58 59.

Decision rationale: California MTUS states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement a total of up to 18 visits over 6-8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. Treatment beyond 4-6 visits should be documented with objective improvement in function. 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. The clinical documentation submitted for review indicated the patient had recently undergone 8 additional sessions of chiropractic care and completed the course with improvement. It was indicated the patient's ADLs and functional abilities improved. The patient had a 60% overall improvement with less pain and less frequency of pain. It was indicated the patient had an improved ability to do ADLs and home exercises. However, there was a lack of documentation indicating what ADLs the patient previously had trouble with and had now improved to support objective functional improvement. Given the above, the request for additional chiropractic visits x7 for the cervical and lumbar spine is not medically necessary.

RIGHT KNEE SYNVISIC INJECTION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Hyaluronic Injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Hyaluronic Injections.

Decision rationale: Official Disability Guidelines recommend hyaluronic acid injections for patients who experience significantly symptomatic osteoarthritis but have not responded adequately to recommended conservative non-pharmacologic and pharmacologic treatments or who are intolerant of these therapies after at least 3 months. There should be documentation of symptomatic severe osteoarthritis of the knee which may include bony enlargement, bony tenderness, crepitus on active motion, less than 30 minutes of morning stiffness, no palpable warmth of synovium and over 50 years of age. Additionally, the patient should have pain that interferes with functional activities and is not attributed to other forms of joint disease, and had a failure to adequately respond to aspiration and injection of articular steroids. Hyaluronic injections are not recommended for any other indications. Clinical documentation submitted for

review indicated the patient had a right knee meniscal tear. The documentation including the PR-2 with objective and subjective findings that requested the service was not submitted for review. As such, there was lack of documentation indicating the patient met the above criteria. The request as submitted failed to indicate the quantity of injections being requested. Given the above, the request for right knee Synvisc injections is not medically necessary.

POOL THERAPY (2X4) FOR THE CERVICAL AND LUMBAR SPINES AND RIGHT KNEE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy, Physical Medicine, Page(s): 22 98 99.

Decision rationale: California MTUS guidelines recommend aquatic therapy as an optional form of exercise therapy that is specifically recommended where reduced weight bearing is desirable. The guidelines indicate the treatment for Myalgia and myositis is 9-10 visits. The clinical documentation submitted for review failed to indicate the number of visits the patient had participated in. There was a lack of documented objective functional improvement with the aquatic therapy. Additionally, there was a lack of documentation indicating the patient had a necessity for reduced weight bearing. Given the above, the request for pool therapy 2 x 4 for the cervical and lumbar spine and right knee is not medically necessary.

YEARLY GYM MEMBERSHIP FOR SELF-DIRECTED WARM WATER EXERCISE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Gym memberships.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Back Chapter, Gym Memberships.

Decision rationale: Official Disability Guidelines do not recommend gym memberships unless a home exercise program is ineffective and there is a need for equipment. Gym memberships would generally not be considered medical treatment and are not covered under the disability guidelines. The clinical documentation submitted for review failed to provide a documented necessity that the patient had an inability to utilize home exercise equipment. The request as submitted failed to indicate the duration for the yearly gym memberships being requested. Given the above, the request for yearly gym membership for self-directed warm water exercise is not medically necessary.

PROVIGIL 400MG, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Provigil.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Provigil.

Decision rationale: Official Disability Guidelines do not recommend Provigil solely to counteract sedative effects of narcotics until after first considering reducing excessive narcotic prescribing. The indications include to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea, and shift work sleep disorder. Patients should have a complete evaluation with a diagnosis made in accordance with the International Classification of Sleep Disorders or DSM Diagnostic Classification. The clinical documentation submitted for review indicated the patient had been on the medication since 03/2013. There was a lack of documentation including a rationale for the medication. There was a lack of documentation of objective functional benefit of the medication. Given the above, the request for Provigil 400 mg #30 is not medically necessary.

PROTONIX 40MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, Page(s): 69.

Decision rationale: California MTUS Guidelines recommend PPIs for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the patient had been taking the medication since 03/2013. There was a lack of documentation of the efficacy of the requested medication. Additionally, the NSAID was being reviewed and was found not to be medically necessary. As such, the request for Protonix 40 mg #30 is not medically necessary.

FLEXERIL 10MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page(s): 63.

Decision rationale: California MTUS Guidelines recommend muscle relaxants as a second line option for the short-term treatment for acute pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review provided evidence that the patient has been on the

medication for an extended duration of time and there is a lack of documentation of objective functional improvement. Given the above, the request for Flexeril 10 mg #30 is not medically necessary.

MOTRIN 800MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, Page(s): 67.

Decision rationale: California MTUS Guidelines indicate that NSAIDS are recommended for the short-term symptomatic relief of pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the patient had been on the medication for greater than 6 months. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The as submitted failed to indicate the quantity of medication being requested. Given the above, the request for Motrin 800 mg is not medically necessary.

LIDODERM PATCHES #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm, Page(s): 56 57.

Decision rationale: California MTUS guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). The clinical documentation submitted for review failed to indicate the patient had a trial and failure of first line medication therapy. It was indicated the patient had been on the medication since 05/2013. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the strength of the medication. Given the above, the request for Lidoderm patches #90 is not medically necessary.

NUCYNTA ER 150MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, Opioids, dosing, Page(s): 60 78 86.

Decision rationale: California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the patient is being monitored for aberrant drug behavior and side effects. The cumulative dosing should not exceed 120 mg oral morphine equivalents per day. The clinical documentation submitted for review failed to meet the above criteria. The patient had been noted to be on the opiates for greater than 6 months. The quantity of the medication being requested was not provided. Given the above and the lack of documentation, the request for Nucynta ER 150 mg is not medically necessary.

NUCYNTA 100MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, Opioids, dosing, Page(s): 60 78 86.

Decision rationale: California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the patient is being monitored for aberrant drug behavior and side effects. The cumulative dosing should not exceed 120 mg oral morphine equivalents per day. The clinical documentation submitted for review failed to meet the above criteria. The patient had been noted to be on the opiates for greater than 6 months. The quantity of the medication being requested was not provided. Given the above and the lack of documentation, the request for Nucynta 100 mg is not medically necessary.

XANAX 1MG #60: Upheld

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

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

Decision rationale: California MTUS Guidelines do not recommend the use of benzodiazepines for the treatment of patients with chronic pain for longer than 3 weeks due to a high risk of psychological and physiological dependence. The clinical documentation submitted for review provides evidence that the patient has been on the medication for an extended duration of time. There was a lack of documentation of objective functional improvement. Given the above, the request for Xanax 1 mg #60 is not medically necessary.