MAXIMUS Federal Services

Case Number:	CM13-0065369		
Date Assigned:	01/03/2014	Date of Injury:	05/01/2012
Decision Date:	05/27/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/13/2013

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 patient is a 53-year-old female who reported an injury on 05/01/2012 after a fall off of a stepladder. The patient reportedly sustained an injury to the neck and low back. The patient's treatment history included physical therapy, aqua therapy, and opioid therapy. The patient's most recent clinical evaluation documented the patient had neck pain rated at 3/10 radiating into the right shoulder with stiffness and low back pain rated at 9/10 radiating into the bilateral lower extremities. Physical findings included a positive straight leg raise test, a positive Bragard's test to the right, and a positive bilateral sciatica notch test with decreased sensation on the L4-5 and L5-S1 dermatomes. The patient's diagnoses included status post lumbar fusion, lumbar L5 radiculopathy, fibromyalgia, and chronic pain syndrome. The patient's treatment recommendations included additional physical therapy, pain management consultation, multidisciplinary pain management program, psychological consultation, continued use of medications, and the use of a peripheral percutaneous neurostimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCUTANEOUS ELECTRICAL STIMULATION (NEUROSTIMULATOR), EACH TREATMENT WITH 4 DAYS OF CONTINUOUS PERCUTANEOUS ELECTRICAL STIMULATION OF TARGETED PERIPHERAL NERVES, 3 TREATMENTS OVER 30 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous electrical nerve stimulation (PENS), Page(s): 98.

Decision rationale: The requested percutaneous electric stimulation (neurostimulator) each treatment with 4 days of continuous percutaneous electrical stimulation of targeted peripheral nerves 3 treatments over 30 days is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does support the use of this type of treatment modality as an adjunct therapy to active physical therapy for patients who have failed all other chronic pain management treatments. The clinical documentation does indicate the patient has continued pain complaints that may benefit from this type of therapy that have failed to respond to other types of chronic pain treatments. However, there is no documentation the patient is currently participating in any type of active of active therapy that would benefit from the addition of this treatment modality. As such, the requested percutaneous electrical stimulation (neurostimulator) each treatment with 4 days of continuous percutaneous electrical stimulation of targeted peripheral nerves 3 treatments over 30 days is not medically necessary or appropriate.

INTENSIVE MULTIDISCIPLINARY PAIN MANAGEMENT PROGRAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Program (Functional Restoration Programs), Page(s): 30.

Decision rationale: The requested intensive multidisciplinary pain management program is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends these types of programs for patients who are motivated to change and have baseline assessments of physical and psychological deficits that would appropriately respond to this type of multidisciplinary treatment. California Medical Treatment Utilization Schedule also recommends that all negative predicators be identified and addressed prior to entry into a multidisciplinary pain management program. The clinical documentation submitted for review fails to provide any evidence that the patient is motivated to participate in this type of program with the goal of changing current attitudes towards treatment. The clinical documentation fails to provide the patient has undergone a baseline physical and psychological evaluation that would provide evidence and support the efficacy of this treatment modality. Additionally, there is no documentation that all negative predicators for this patient have been addressed. As such, the requested intensive multidisciplinary pain management program is not medically necessary or appropriate.

TRAMADOL FOR PAIN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: The requested tramadol for pain is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends that the continued use of opioids be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence the patient is monitored for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is monitored for aberrant behavior. The clinical documentation also indicates the patient has been on this medication since at least 06/2013. The clinical documentation fails to provide an adequate assessment of pain relief or functional benefit to support continued use for this patient. Also, the request as it is written does not provide a dosage, frequency, or duration of treatment. Therefore, the appropriateness of this medication cannot clearly be determined. As such, the requested tramadol for pain is not medically necessary or appropriate.

PRILOSEC 20MG PO QHS: 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: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk, page 68.

Decision rationale: The requested Prilosec 20 mg every night is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for patients who are at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support the need for a gastrointestinal protectant for this patient. Therefore, continued use would not be supported. As such, the requested Prilosec 20 mg by mouth every night is not medically necessary or appropriate.

FLEXERIL 10MG PO QHS: Upheld

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

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

Decision rationale: The requested Flexeril 10 mg by mouth every night is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the extended use of muscle relaxants for patients with chronic pain. California Medical Treatment Utilization Schedule recommends muscle relaxants be used for acute exacerbations for treatment duration not to exceed 2 to 3 weeks. The clinical documentation submitted for review does not provide any evidence that this is an acute exacerbation of the

patient's chronic pain. Therefore, the use of a muscle relaxant would not be supported. As such, the requested Flexeril 10 mg by mouth every night is not medically necessary or appropriate.