MAXIMUS Federal Services

Case Number:	CM14-0001317		
Date Assigned:	01/22/2014	Date of Injury:	11/24/2010
Decision Date:	08/22/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	12/30/2013

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 Occupational Medicine and is licensed to practice in California. 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 52 year old female who was injured on 11/24/2010. Mechanism of injury is unknown.Prior treatment history has included records indicating that the patient underwent acupuncture and aquatic therapy (08/15/2012). She has had surgery to her right ankle. Diagnostic studies reviewed include MRI of the lumbar spine dated 12/30/2013 revealing L4-L5 there is a 3 mm left foraminal disc protrusion with abutment of the exiting left L4 nerve root. Progress note dated 07/16/2013 documented the patient with complaints of back pain, right knee pain, numbness and tingling in the right hand, neck pain and numbness and tingling in the right leg. Her main complaints are really about her lower back, numbness and tingling in right leg and right hand and a trigger finger of her right hand. Walking and standing make it worse. She is now taking tramadol, tizanidine, naproxen, and gabapentin. She does not do therapy. Objective findings on examination of the cervical spine reveal the neck is very tender. She has decreased motion. Lateral rotation is 70 degrees to the right and 60 degrees to the left. Examination of the right shoulder reveals she has forward flexion abduction impingement. The AC joint is nontender. Examination of the left shoulder reveals she has mild impingement with positive Neer sign on the left shoulder. Her grip strength on the right is 10, 10, and 12. Examination of the lumbar spine reveals range of motion on forward flexion to be 40 degrees and extension 20 degrees. She is very tender about the back. Straight leg raise is positive at 80 degrees on the left and 70 degrees on the right. Examination of the right knee reveals flexion 120 degrees. She has positive patellofemoral grind test. Positive medial joint line tenderness and positive McMurray test. Diagnoses:1.Chronic non-radicular lumbar spine pain. 2.Chronic non-radicular cervical spine strain. 3.Tendinitis right knee.4.Possible carpal tunnel syndrome right hand. Future Medical Care: She should have access to MRI and injections in the future, EMG/NCV velocity tests for the upper extremities and physical therapy. For her knee she should have MRI, anti-

inflammatories and physical therapy. UR report dated 12/30/2013 denied the request for chiropractic treatment for the knee. Guidelines do not recommend this and there are no studies that manipulation is proven effective with knee and leg complaints. The request for a urine drug screen was denied as there was no documentation in the records provided when this patient last had a drug screen and what the outcome was. The request for Ultram was denied as no prior functional improvement with prior use of this medication was noted. None of the criteria are addressed in the documentation submitted. The request for Zanaflex was denied because there was no documentation that this patient had functional improvement with prior use of this medication. The request for right knee injection under ultrasound guidance was denied because in this case, there is no documentation in the records provided that this patient satisfies 5 of the 9 criteria in the guidelines established by the American College of Rheumatology. The request for Neurontin was denied because there is no documentation of functional improvement with the prior use of this medication. For continuation of use, there needs to be documentation of satisfactory response to treatment to include decreased pain, increased level of function or improved quality of life.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENT TWO (2) TIMES WEEKLY, FOR FOUR (4) WEEKS, FOR LOW BACK AND RIGHT KNEE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58-56.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: According to the CA MTUS guidelines, chiropractic manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. 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. According to the guidelines, manipulative therapy is not recommended for the knee. However, this intervention may be recommended as an option for treatment of the low back. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. The guidelines state trial of 6 visits over 2 weeks is recommended. The request for 8 sessions of chiropractic to the low back and right knee is not supported by the guidelines.

RIGHT KNEE INJECTION UNDER ULTRASOUND GUIDANCE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 1021-1022. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, Corticosteroid 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, Corticosteroid injections.

Decision rationale: According to the Official Disability Guidelines, Corticosteroid injections are recommended for short-term use only. Intra-articular corticosteroid injection results in clinically and statistically significant reduction in osteoarthritic knee pain 1 week after injection. The beneficial effect could last for 3 to 4 weeks, but is unlikely to continue beyond that. The guidelines state that in the knee, conventional anatomical guidance by an experienced clinician is generally adequate. Ultrasound guidance for knee joint injections is not generally necessary. According to the medical records, the patient's diagnosis is right knee tendonitis. The medical records do not establish this patient has symptomatic severe OA of the knee that is not adequately controlled by recommended conservative treatments. In addition, per the ODG, Criteria for Intraarticular glucocorticosteroid injections, according to the American College of Rheumatology criteria, require in addition to knee pain, at least 5 of the following: (1) Bony enlargement; (2) Bony tenderness; (3) Crepitus (noisy, grating sound) on active motion; (4) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr; (5) Less than 30 minutes of morning stiffness; (6) No palpable warmth of synovium; (7) Over 50 years of age; (8) Rheumatoid factor less than 1:40 titer (agglutination method); and (9) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3). The medical records do not establish this patient is a candidate for knee injection.

URINE DRUG SCREEN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-80, 94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Opioids, indicators for addiction Page(s): 87-91.

Decision rationale: According to the CA MTUS guidelines, urine drug testing is recommended for patients on chronic opioid therapy. High risk of abuse or aberrant behavior is not documented. The timing and frequency of prior drug screens is not documented. Medical necessity is not established.

ULTRAM 50 MG (#120) PRESCIRBED 12/09/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: According to MTUS guidelines, opioids may be indicated for moderate to severe pain. Long-term use may be warranted if functional improvement is demonstrated, though efficacy of long-term use is not clearly established. In this case the patient is prescribed

Tramadol on a long-term basis for chronic back, neck and knee pain. The patient reports improvement in pain and function. However, history and examination findings do not demonstrate objective functional improvement, pain reduction or reduction in dependency on medical care from use of Tramadol. The patient continues to complain of severe pain and dysfunction. She is not working. Medical necessity is not established.

ZANAFLEX 4 MG (#90): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex) Page(s): 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: According to MTUS guidelines, muscle relaxants are recommended second-line for the short-term treatment of acute exacerbations of chronic low back pain. In this case the patient is prescribed Zanaflex on a long-term basis for chronic pain. However, long-term use is not recommended by guidelines. Further, history and examination findings fail to demonstrate objective clinically significant functional improvement, pain reduction, or reduction in dependency in medical care from use of Zanaflex. Medical necessity is not established.

NEURONTIN 600 MG (#60) PRESCIRBED 12/09/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19.

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

Decision rationale: According to MTUS guidelines, Gabapentin is considered as a first-line treatment for neuropathic pain. In this case Gabapentin is prescribed on a long-term basis for lumbar radiculopathy. However, the patient's right lower extremity radicular complaints are neither clearly confirmed by physical examination nor MRI. There are conflicting examination findings by different providers. Lumbar MRI on 12/30/13 does not show right-sided nerve compromise. As such neuropathic pain remains questionable. Further, history and physical examination do not demonstrate clinically significant functional improvement or pain reduction due to use of Gabapentin. The patient continues to report severe pain and dysfunction and is not working. Medical necessity is not established.