MAXIMUS Federal Services

Case Number:	CM14-0012855		
Date Assigned:	02/24/2014	Date of Injury:	04/14/2010
Decision Date:	08/05/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	01/31/2014

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 Management and is licensed to practice in Tennessee. 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 40-year-old female who has filed a claim for left lower extremity complex regional pain syndrome associated with an industrial injury date of April 14, 2010. Review of progress notes indicates bilateral shoulder and hip pain; neck and low back pain; and left lower extremity symptoms from the knee distally with numbness, tingling, and burning. Patient reports improvement of overall condition with chiropractic therapy and acupuncture. Findings include severely antalgic gait; tenderness over the cervical, thoracic, and lumbar paraspinals with decreased ranges of motion; decreased sensation in the left L4, L5, and S1 distributions; weakness of the left EHL and evertors; left calf atrophy; right shoulder pain with movement and decreased strength; and crepitus with movement of the right shoulder. An MRI of the right hip dated August 22, 2012 was unremarkable. An MRI of the left hip showed joint effusion with synovitis. An MRI of the lumbar spine dated January 07, 2013 showed degenerative disc disease and retrolisthesis at L4-5 and L5-S1, and mild caudal right neuroforaminal narrowing at L4-5. The MRI of the cervical spine showed degenerative disc disease. X-rays of the pelvis dated July 25, 2013 showed mild bilateral hip and sacroiliac joint degenerative disease. Treatment to date has included chiropractic therapy, left sacroiliac joint injection, injection to the bilateral hips, muscle relaxants, physical therapy, home exercise program, acupuncture to the lumbar spine, AFO brace on the left, opioids, gabapentin, prednisone, triptans, sedatives, antidepressants, and Lidoderm. Of note, patient had left ankle surgery on August 17, 2011. Utilization review from January 27, 2014 denied the requests for ondansetron 4mg #20 as there was no documentation of chemotherapy; cyclobenzaprine 75mg #10 as there was no documentation of muscle spasms or previous improvement with this medication; and chiropractic treatments left hip #8 as there was no documentation of objective functional benefits from previous sessions. There was modified

for acupuncture treatments for the lumbar spine for 4 visits as this is not recommended for neck pain. Reason for denial of trazodone 50mg #120 was not indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE TREATMENTS NECK AND LUMBAR SPINE QUANTITY: 8.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: As noted on page 114 of the California MTUS ACOEM Guidelines, they stress the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician is paramount. In addition, Acupuncture Medical Treatment Guidelines state that acupuncture may be 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. Functional improvement should be observed within 3-6 treatments, with treatments rendered 1 to 3 times per week and an optimum duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. This patient has had previous acupuncture sessions. There is no documentation regarding the total amount of sessions attended, but documentation notes 42 visits. The patient reports pain relief with acupuncture and improved function. This patient has had extensive acupuncture therapy, and acupuncture treatment notes indicate that further sessions are indicated with acute flare-ups of pain. There is no recent documentation of acute exacerbations of neck and low back pain. Therefore, the request for acupuncture treatments for the neck and lumbar spine #8 was not medically necessary.

ONDANSETRON 4MG QUANTITY: 20.00: Upheld

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

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, Antiemetics (for opioid nausea).

Decision rationale: The California MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, ondansetron is recommended for nausea and vomiting secondary to chemotherapy, radiation, and post operative use. Acute use is FDA-approved for gastroenteritis. It is not recommended for nausea and vomiting secondary to chronic opioid use. Although the patient reports nausea and vomiting due

to medication intake, here is no documentation regarding chemotherapy, radiation therapy, or recent surgery to support this request. Therefore, the request for ondansetron 4mg #20 was not medically necessary.

TRAZADONE 50 MG. QUANTITY: 120.00: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Trazodone (Desyrel).

Decision rationale: The California MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. The ODG recommends Trazodone as an option for insomnia only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. Trazodone has also been used successfully in fibromyalgia. Patient has been on this medication since September 2013. There is no recent documentation of sleep issues in this patient, or of the benefits derived from this medication. Additional information is necessary to support this request. Therefore, the request for trazodone 50mg #120 was not medically necessary.

CYCLOBENZAPRINE 75 MG. QUANTITY: 10.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state that cyclobenzaprine is a skeletal muscle relaxant and a CNS depressant that is recommended as a short-course therapy. The effect is greatest in the first 4 days of treatment. Patient has been on this medication since September 2013. There is no documentation of recent acute exacerbations of pain or of significant muscle spasms. Also, this medication is not recommended for chronic use. Therefore, the request for cyclobenzaprine 75mg #10 was not medically necessary.

CHIROPRACTIC TREATMENTS LEFT HIP QUANTITY: 8.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

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

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state that the goal of manual therapy is to achieve positive symptomatic or objective measurable functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the low back, trial of 6 visits is recommended, and with evidence of objective functional improvement, a total of up to 18 visits is supported. In addition, elective/maintenance care is not medically necessary. Patient has had more than 24 chiropractic therapy sessions. The patient reports very helpful in reducing pain levels. However, the patient exceeds the number of sessions than recommended, and there is no documentation of worsening of pain symptoms to support additional sessions. Therefore, the request for chiropractic treatments left hip #8 was not medically necessary.