

Case Number:	CM14-0137372		
Date Assigned:	09/05/2014	Date of Injury:	02/14/2011
Decision Date:	11/03/2014	UR Denial Date:	07/24/2014
Priority:	Standard	Application Received:	08/25/2014

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 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:

Patient is a 37-year-old female who has submitted a claim for chronic low back pain syndrome with radiculitis, bilateral carpal tunnel syndrome, anxiety, depression, and insomnia associated with an industrial injury date of 2/14/2011. Medical records from 2013 to 2014 were reviewed. Patient was able to return to work under modified duties. However, her psychological symptoms have exacerbated due to an incident wherein the supervisor suspended her for having shared her pain medication with a coworker. Her anxiety aggravated. She likewise complained of severe depression and difficulty falling asleep. Patient reported that previous physical therapy and chiropractic care helped improve her condition temporarily. Patient complained of constant, severe, burning low back pain, radiating to bilateral lower extremities, associated with numbness and tingling sensation. Patient likewise complained of bilateral wrist pain associated with weakness and tingling sensation. Anthropometric examination showed a weight of 162 pounds, height of 5 feet 3 inches, and derived body mass index of 28.7 kg/m². Physical examination of the lumbar spine showed tenderness, muscle spasm, restricted motion, and positive bilateral straight leg raise test. Examination of both wrists showed tenderness, painful motion, positive Tinel's sign, and positive Finkelstein's test. MRI of the lumbar spine, dated 1/31/2014, showed multi-level disc protrusion at L4 to L5 and L5 to S1 with stenosis of the spinal canal, bilateral lateral recess and bilateral neural foramina stenosis. EMG/NCV of the bilateral lower extremities, dated 12/27/2013, showed normal findings. Treatment to date has included 12 sessions of physical therapy, 14 sessions of chiropractic treatment, 19 sessions of acupuncture, home exercise program, use of interferential unit (since April 2014), use of a back brace, and medications such as amitriptyline, soma (since May 2014), hydrocodone, Xanax, naproxen, and topical cream. Utilization review from 7/23/2014 denied the request for aquatic therapy because of no evidence of functional gains from previous supervised therapy; denied chiropractic

evaluation and treatment because patient was already on a home exercise program; certified request for pain management for possible epidural injection because of ongoing complaints of low back pain despite conservative care; denied interferential therapy for use at home because of no evidence of functional benefit from previous use; certified amitriptyline 25 mg, #30 because patient had chronic pain with neuropathic component and likewise reported symptoms of depression and anxiety; and denied Soma, #60 because of no evidence of significant functional benefit or analgesic relief from previous use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic Therapy: 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 Aquatic Therapy Page(s): 22-23.

Decision rationale: As stated on pages 22-23 of the California MTUS Chronic Pain Medical Treatment Guidelines, aquatic therapy is recommended as an alternative to land-based physical therapy where reduced weight bearing is desirable such as extreme obesity or fractures of the lower extremity. In this case, patient completed 12 sessions of physical therapy. However, there is no discussion as to why patient should be enrolled in aquatic therapy at this time. Body mass index is 28.7 kg/m². There is likewise no lower extremity fracture noted on the record submitted. There is no clear evidence why patient cannot participate in a land-based physical therapy. Moreover, the present request as submitted failed to indicate body part to be treated and number of therapy sessions. Therefore, the request for aquatic therapy is not medically necessary.

Chiropractic Evaluation and Treatment: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manipulation Therapy Page(s): 58-59. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) <Chapter 7, Independent Medical Examinations and Consultations, page(s) <127>

Decision rationale: As stated on page 127 of the California MTUS ACOEM Independent Medical Examinations and Consultations Chapter, occupational health practitioners may refer to other specialists if the diagnosis is uncertain, or when psychosocial factors are present. As stated on pages 58-59 of CA MTUS Chronic Pain Medical Treatment Guidelines, several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although

improvement tapered off after the initial sessions. There should be some outward sign of subjective or objective improvement within the first 6 visits for continuing treatment. In this case, patient completed 14 sessions of chiropractic treatment. She reported that that previous sessions helped improve her condition temporarily. However, there is no objective evidence of functional improvement with previous sessions. Moreover, the present request as submitted failed to indicate body part to be treated and number of intended therapy sessions. Manipulation therapy is not indicated for wrist pain. The request is incomplete; therefore, the request for chiropractic evaluation and treatment is not medically necessary.

Refer to Pain Management for Possible Epidural Injections: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): Chapter 7 Independent Medical Examinations and Consultations.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) <Chapter 7, Independent Medical Examinations and Consultations, page(s) <127>

Decision rationale: As stated on page 127 of the California MTUS ACOEM Independent Medical Examinations and Consultations Chapter, occupational health practitioners may refer to other specialists if the diagnosis is uncertain, or when psychosocial factors are present. As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. In this case, patient complained of constant low back pain radiating to bilateral lower extremities, associated with numbness and tingling sensation. Physical examination of the lumbar spine showed tenderness, muscle spasm, restricted motion, and positive bilateral straight leg raise test. Symptoms persisted despite physical therapy, chiropractic treatment, acupuncture, and medications. Moreover, MRI of the lumbar spine from 1/31/2014 showed multi-level disk protrusion causing bilateral neural foramina stenoses. However, there is no neurologic examination available to document presence of radiculopathy. The medical necessity for ESI cannot be established due to insufficient information. Lastly, utilization review from 7/23/2014 already certified this request. Therefore, request for referral to pain management for possible epidural injection is not medically necessary.

IF-4 Unit for Use At Home for Lumbar Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Page(s): 118-120.

Decision rationale: As stated on pages 118-120 of the California MTUS Chronic Pain Medical Treatment Guidelines, interferential current stimulation is not recommended as an isolated intervention but is an adjunct for recommended treatments including return to work, exercise, and medications. A one-month trial should be done given that the patient's pain is ineffectively controlled by medications, or unresponsive to conservative measures. In this case, progress report from April 2014 stated that patient was already using interferential therapy at home. There is no discussion why another unit is being requested at this time. Moreover, there is no evidence of pain relief and functional benefit from previous use. The medical necessity cannot be established due to insufficient information. Therefore, the request for interferential unit for use at home for the lumbar spine is not medically necessary.

Amitriptyline 25mg #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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-14.

Decision rationale: As stated on page 14 of CA MTUS Chronic Pain Medical Treatment Guidelines, tricyclic antidepressants, such as amitriptyline and nortriptyline, are recommended as a first-line option for neuropathic pain, especially if pain is accompanied by insomnia, anxiety, or depression. In this case, there is no prior use of amitriptyline. The patient complains of low back pain radiating to bilateral lower extremities, consistent with neuropathy. Moreover, patient reports symptoms of anxiety, depression, and sleep disturbance. The medical necessity for prescription of tricyclic antidepressant has been established. However, utilization review from 7/23/2014 already certified this request. Therefore, the request for amitriptyline 25 mg, #30 is not medically necessary.

Soma #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma, Carisoprodol (Soma).

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

Decision rationale: As stated on page 29 of CA MTUS Chronic Pain Medical Treatment Guidelines, carisoprodol (Soma) is a centrally acting skeletal muscle relaxant that is not indicated for long-term use. Carisoprodol abuse has been noted in order to augment or alter effects of other drugs such as hydrocodone, tramadol, benzodiazepine and codeine. In this case, there is no prior use of carisoprodol. The most recent physical examination showed evidence of paralumbar muscle spasm. Use of Soma is a reasonable treatment option at this time. However,

the present request as submitted failed to indicate dosage of Soma. The request is incomplete; therefore, the request for Soma, #60 is not medically necessary.