

Case Number:	CM14-0167074		
Date Assigned:	10/14/2014	Date of Injury:	05/14/2013
Decision Date:	11/17/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/10/2014

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 Physical Medicine & Rehabilitation and Pain 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 injured worker is a 56-year-old male who sustained an injury on 5/14/13. As per 7/31/14 report, he complained of neck and low back (mostly left-sided) pain which was a constant stabbing, aching pain radiating down the left lower extremity. An exam revealed mildly antalgic gait, decreased ROM of the L-spine, and pain with facet loading and palpation tenderness in the left lower lumbar facet regions, and hyperesthesia L4 through S1 dermatomes on the left. L-spine MRI dated 8/21/13 revealed multilevel disc herniations with neural foraminal narrowing and facet arthropathy of L-spine. A right knee MRI dated 6/20/13 revealed medial meniscus tear, discoid lateral meniscus and evidence of three compartment osteoarthritis, worse in the medial compartment. Left knee MRI dated 8/21/13 revealed mild medial compartment osteoarthritis, evidence of chronic attenuated partial ACL tear. Past surgeries included right knee arthroscopy on 3/31/14. He is currently on Norco, gabapentin, and Tylenol. He had L4 and L5 epidural injections on the left on 8/15/14 and acupuncture. Medications helped decrease his pain by about 30% and allowed him to increase his walking distance by about 20 minutes. The chiropractic treatment was recommended for the low back due to the benefit he had with chiropractic treatment in the past and in an attempt to help decrease pain and increase strength, ROM and functional capacity. Diagnoses include multilevel disc herniations of lumbar spine with neural foraminal narrowing and facet arthropathy of lumbar spine, right knee medial meniscus tear, bilateral shoulder impingement, left knee partial ACL tear, bilateral AC arthrosis, and bilateral lateral epicondylitis. The request for Norco 10/325mg up to 3 x a day needed for severe pain, QTY. 90, Gabapentin 600mg, 1 tablet 2 x a day, QTY. 60, 8 Chiropractic treatments for the back, Additional 7 visits of Physical Therapy to the right knee, U/S of the right lower extremity, and repeat MRI of the right knee was deemed not medically necessary on 9/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg up to 3 x a day needed for severe pain, QTY. 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 91, 74.

Decision rationale: Norco (Hydrocodone + Acetaminophen) is indicated for moderate to severe pain. It is classified as a short-acting opioids, often used for intermittent or breakthrough pain. Guidelines indicate "four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. The guidelines state continuation of opioids is recommended if the patient has returned to work and if the patient has improved functioning and pain. The medical records do not establish failure of non-opioid analgesics, such as NSAIDs, and there is no mention of ongoing non-pharmacologic methods of pain management such as home exercise program. There is little to no documentation of any significant improvement in pain level (i.e. VAS) or function pertinent to its prior use. There is no evidence of urine drug test in order to monitor compliance. Furthermore, long-acting opioids should be considered when continuous around the clock pain management is desired. Therefore, the medical necessity for Norco has not been established based on guidelines and lack of documentation.

Gabapentin 600mg, 1 tablet 2 x a day, QTY. 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GABAPENTIN Page(s): 16-18.

Decision rationale: According to the guidelines, an anti-epilepsy drug (AED), such as Gabapentin (Neurontin) is recommended for neuropathic pain. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and post-therapeutic neuralgia and has been considered as a first-line treatment for neuropathic pain. In this case, the IW is noted to have clinical evidence of lumbar radiculopathy associated with lumbar degenerative disc disease. However, the records do not document any significant improvement in radiating pain down the left leg with continuous use. Therefore, the medical necessity of Gabapentin has not been established under the guidelines and based on the available information.

8 Chiropractic treatments for the back: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY Page(s): 58.

Decision rationale: According to the CA MTUS guidelines, chiropractic treatment may be appropriate for treatment of chronic pain patients, in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. For therapeutic care of the low back, the guidelines recommend a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, may be recommended. The medical records indicate that the IW has received unknown number of chiropractic visits in the past; however, there is no record of progress notes documenting any significant improvement in the objective measurements (i.e. pain level, ROM, strength). Furthermore, additional chiropractic treatments might exceed the guidelines recommendation; thus, the request is not medically necessary per guidelines and based on the submitted clinical information.

Additional 7 visits of Physical Therapy to the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98.

Decision rationale: As per CA MTUS guidelines, physical medicine is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. As per ODG guidelines, Physical Therapy (PT) is recommended for chronic knee pain; allowing for physical therapy; 9 visits over 8 weeks for the knee arthritis, pain or derangement of meniscus and 12 visits over 12 weeks for post-surgical PT. In this case, the IW has received unknown number of PT visits; however, there is no record of progress notes documenting any improvement in the objective measurements (i.e. pain, ROM, strength) in order to support additional PT visits. Nonetheless, there is no mention of the patient utilizing an HEP (At this juncture, this patient should be well-versed in an independently applied home exercise program, with which to address residual complaints, and maintain functional levels). There is no evidence of presentation of any new injury / surgical intervention to warrant more therapy. Moreover, additional PT visits would exceed the guidelines criteria. Therefore, the request is considered not medically necessary or appropriate in accordance with the guideline.

U/S of the right lower extremity: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE

Decision rationale: The CA MTUS/ACOEM guidelines do not address the issue. Thus, the NIH/Medline was consulted. Indications for ultrasound of the lower extremity include arteriosclerosis, venous insufficiency and DVT. In this case, the medical records do not document a clinical evidence suggestive of DVT or a vascular pathology. As such, the request is considered not medically necessary based on the submitted clinical information.

Repeat MRI of the right knee: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) KNEE

Decision rationale: Per CA MTUS/ACOEM guidelines, the criteria for MRI of the knee includes documentation of unstable knee (with documented episodes of locking, popping, giving away, recurrent effusion, signs of bucket handle tear), and to determine the extent of ACL tear preoperatively. Per ODG, criteria for MRI of the knee include significant trauma (i.e. MVA), suspected posterior dislocation, evidence of internal derangement on X-ray or post-surgically to assess knee cartilage repair. In this case, there is no documented evidence of any of the above conditions. Furthermore, the records show that the IW had right knee MRI done on 6/20/13 (which revealed medial meniscus tear, discoid lateral meniscus and evidence of three compartment osteoarthritis, worse in the medial compartment). There is no documentation of worsening of symptoms and it is not clear as to why a repeat MRI has been requested. Therefore, the medical necessity of the request cannot be established based on the clinical information and guidelines.