

Case Number:	CM14-0184048		
Date Assigned:	11/10/2014	Date of Injury:	06/20/2006
Decision Date:	12/18/2014	UR Denial Date:	10/18/2014
Priority:	Standard	Application Received:	11/05/2014

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 General Preventive Medicine and is licensed to practice in Indiana. 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:

This employee is a 43 year old male with date of injury of 6/20/2006. A review of the medical records indicates that the patient is undergoing treatment for cervicalgia, lumbago with radiculopathy, and left shoulder pain. Subjective complaints include continued pain in the neck and lower back with some bilateral radiation to lower extremities; pain in the left shoulder. Objective findings include limited range of the cervical and lumbar spine with tenderness to palpation and positive straight leg raise bilaterally; limited range of motion of the left shoulder; sensory exam normal bilaterally. Treatment has included 20 previous sessions of physical therapy, a previous ESI at the L4 level, and Norco. The utilization review dated 10/18/2014 partially-certified 12 sessions of physical therapy, a referral to an orthopedist, ESI at bilateral L4, Norco #150, Lexapro #60, and Lunesta #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve (12) physical therapy visits: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 134,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine

Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Medical records indicate 20 sessions were tried for the cervical spine. However, this request is for the lumbar spine. Twelve sessions is beyond the 6 session trial recommended by ODG; therefore the request for 12 sessions of physical therapy is not medically necessary.

Referral to orthopedist within MPN: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: The ACOEM Guidelines indicate that a: "Referral for surgical consultation may be indicated for patients who have: - Red-flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.)- Activity limitation for more than four months, plus existence of a surgical lesion- Failure to increase ROM and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion- Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair" This employee does not meet any of these criteria, and therefore, the referral to an orthopedist is not medically necessary.

Transforaminal epidural steroid injection at bilateral L4 level: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Epidural steroid injections (ESIs)

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) . . . Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab

efforts, including continuing a home exercise program." MTUS further defines the criteria for epidural steroid injections to include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, 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, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The employee had a previous ESI of the same level several months prior with a 70% reduction in pain. Therefore, he meets the criteria above for a repeat injection. The request for Transforaminal epidural steroid injection at bilateral L4 level is medically necessary.

Norco 10/325mg #150 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute and Chronic), Low Back - Lumbar & Thoracic (Acute & Chronic), Shoulder, Pain, Opioids

Decision rationale: ODG does not recommend the use of opioids for neck, low back, and shoulder pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. Additionally, medical documents indicate that the patient has been on Norco in excess of the recommended 2-week limit. As such, the question for Norco is not medically necessary.

Lexapro 20mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Lexapro

Decision rationale: Regarding Lexapro, MTUS is silent. ODG states the following: "Recommended as a first-line treatment option for major depressive disorder. See Antidepressants for treatment of MDD (major depressive disorder). See also Selective serotonin reuptake inhibitors (SSRIs). However, MTUS does have recommendation regarding anti-depressants in general. Regarding treatment of Pain with anti-depressants, MTUS and ODG state, "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated." Medical records do not indicate a history of depression or neuropathic pain. Therefore, the request for Lexapro 2mg #60 is not medically necessary.

Lunesta 3mg #30 with 1 refill: 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) Mental Illness & Stress

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, insomnia, Mental Illness, Eszopicolone (Lunesta)

Decision rationale: MTUS is silent specifically regarding eszopicolone (Lunesta), therefore other guidelines were utilized. ODG states regarding Eszopicolone, "Not recommended for long-term use, but recommended for short-term use. See Insomnia treatment. See also the Pain Chapter. Recommend limiting use of hypnotics to three weeks maximum in the first two months of injury only, and discourage use in the chronic phase." For insomnia ODG recommends that "Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. (Lexi-Comp, 2008) Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning." Medical records do not indicate patient's sleep hygiene or the need for variance from the guidelines, such as "a) Wake at the same time every day; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping." Medical documents indicate that the patient has been on Eszopicolone on a time period far exceeding guidelines. Additionally, medical records do not indicate what components of insomnia have been

addressed, treated with conservative measures, and the results of those conservative treatments. As such, the request Lunesta is not medically necessary.