

Case Number:	CM14-0031627		
Date Assigned:	06/20/2014	Date of Injury:	10/06/1998
Decision Date:	07/24/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/12/2014

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 Neurological Surgery 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 62-year-old female who was injured on October 6, 1998. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated January 15, 2014 indicates that there are ongoing complaints of increased vertigo, multiple near syncopal, and lightheadedness episodes; as well as increased fatigue, increase in arm numbness and tingling to twice a month, wakes up from sleep with increased numbness. The injured worker also had complaints of increased knee and bilateral hip pain, right shoulder numbness, headaches with right side facial swelling, increase with cough, tingling, and radiating spinal pain. She had acute episodes of disequilibrium with blurred vision; cervical spinal pain and nocturnal cramping. She also had increased abdominal pain currently being worked up at Kaiser for gallbladder, lower back pain that travels into the left leg. The physical examination demonstrated C-8 atrophy of left hand intrinsic now with triceps and flexor/extensor of arm atrophy is severe. Right C-6 decrease pinprick sensation to light touch, decreased right triceps, positive Tinel's, positive Phalen's. She had decreased range of motion of the left shoulder at 60. She had decreased flexion on the right cervical spine spasm with sustained dystonic contraction. The injured worker was using cane for balance. No diagnostic imaging studies were available for review. Previous treatment includes medications: Gabapentin, Fioricet, Wellbutrin XL, Klonopin, Zantac, Provigil, Prevacid, Zolpidem, and Lorazepam.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription of Botox for cervical dystonia: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin (Botox; Myobloc) Page(s): 25-26.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Botox injections are listed as a recommended treatment for conditions such as cervical dystonia. Although literature states this condition is generally not related to Worker's Compensation injuries, and is characterized as a movement disorder of the nuchal muscles, characterized by tremor, or by tonic posturing of the head in a rotated, twisted, or abnormally flexed or extended position or some combination of these positions. According to medical records reviewed in the physical exam reports objective findings that this patient does have cervical spine spasm with sustained dystonic contraction. Cervical dystonia is also listed as one of the diagnoses. Therefore, the request is medically necessary.

TENS device for cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) device.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

Decision rationale: The Chronic Pain Medical Treatment Guidelines support the use of a transcutaneous electrical nerve stimulator (TENS) unit in certain clinical settings of chronic pain, as a one-month trial when used as an adjunct to a program of evidence-based functional restoration for certain conditions, and for acute postoperative pain in the first 30 days following surgery. Based on the evidence-based trials, there is no support for the use of a TENS unit as a primary treatment modality. The record provides no documentation of a previous 30-day trial to document evidence-based functional improvement or decrease in pain. In the absence of such documentation, this request is not meet guideline criteria for a Tens unit. As such, this request is not medically necessary.

Prescription of Chondrotine/glucosamine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondrotin Sulfate).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondrotin Sulfate) Page(s): 50.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that Glucosamine (and Chondroitin Sulfate) is recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly

significant efficacy for crystalline glucosamine sulphate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride. After careful review of the medical documentation provided there are subjective complaints of increased knee pain and a diagnosis of left knee medial meniscal tear status post-surgery 2008. However, there was not a diagnosis specifically for knee arthritis. This treatment option is appropriate for patients with moderate arthritic pain. Lacking specific clinical documentation, this request is not medically necessary.

Bally's membership: 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), Health Clubs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (acute & chronic), Gym Memberships.

Decision rationale: According to the Official Disability Guidelines (ODG), gym memberships are not recommended as a medical prescription unless a home exercise program has not been effective and there is a need for equipment. In addition, treatment needs to be monitored and administered by medical professionals. While an individual exercise program is of course recommended, more elaborate personal care where outcomes are not monitored by a health professional, such as gym memberships or advanced home exercise equipment, may not be covered under this guideline, although temporary transitional exercise programs may be appropriate for patients who need more supervision. Given the patient's multiple complex medical issues it is not recommended for this patient to attempt exertional exercise in order to improve her condition. However, there is no clear indication that a gym membership constitutes monitored and supervised treatment by a healthcare professional. As such, in accordance with the ODG guidelines the request is not medically necessary.

Orthopedic bed: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Hospital Beds and Accessories, Number: 0543.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Mattress selection, Accessed Online.

Decision rationale: According to the Official Disability Guidelines (ODG) there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. On the other hand, pressure ulcers (e.g., from spinal cord injury) may be treated by special support surfaces (including beds, mattresses and cushions) designed to redistribute pressure. After review of the medical documentation provided there is no mention of

a significant spinal cord injury, or risk of developing pressure ulcers that justify the need for an orthopedic mattress. Therefore, the request is not medically necessary.

Prescription of Fioricet: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, barbiturate-containing analgesic agents (BCAs) are not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. There is a risk of medication overuse as well as rebound headache. Therefore, the request is not medically necessary.

Prescription of Klonopin 0.5mg, two times per day: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative, hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. After reviewing the medical documentation from November 20, 2013, the injured worker does not have an associated anxiety or panic disorder mentioned. Therefore, the request is not medically necessary.

Prescription of Zantac: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 69.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, patients who are experiencing dyspepsia due to the current medication regimen especially those taking non-steroidal anti-inflammatory and/or a SSRI, the appropriate guidance is to stop the NSAID, switch to a different NSAID, or consider a H2-receptor agonist or a PPI. In the clinical documentation provided there is no mention in the PPI, past medical history, or physical exam documenting any Gastro intestinal issues or intolerance of her current medication regimen warranting the above requested Zantac. Therefore, the request is not medically necessary.

Prescription of Provigil: 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, Modafinil (Provigil).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (chronic), Accessed Online.

Decision rationale: According to the Official Disability Guidelines, Provigil is not recommended to counteract sedation effects of narcotics until after first considering reducing excessive narcotic prescribing. According to the medical documentation provided there are no clinical findings to suggest she has a history of narcolepsy, obstructive sleep apnea, or shift work sleep disorder. There is mention of snoring, but without a sleep study there is no corroborative evidence to support the need for this medication. Therefore, the request is not medically necessary.

Prescription of Zolpidem: 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, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic)-(updated 6/10/14).

Decision rationale: According to the Official Disability Guidelines, Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. After reviewing the provided medical records there is no documented objective or clinical findings referencing a diagnosis of insomnia, therefore the request is not medically necessary.

Epidural (unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

Decision rationale: The Chronic Pain Medical Treatment Guidelines allow for epidural steroid injections when radiculopathy is documented on physical examination and corroborated by electrodiagnostic studies or imaging in individuals who have not improved with conservative care. Based on the clinical documentation provided, there is insufficient clinical evidence that the proposed procedure meets guideline criteria. Specifically, there is no objection medical documentation showing at least 50% pain relief with associated reduction of medication use for six to eight weeks. As such, the request is not medically necessary.

Prescription of Ultram: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (criteria for use).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93.94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines support the use of tramadol (Ultram) for short-term use after there is been evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. Given the clinical presentation and lack of documentation of functional improvement with tramadol, the request is not medically necessary.

Ergo Chair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 1 Prevention.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back, Ergonomic Interventions, Accessed Electronically.

Decision rationale: According to the Official Disability Guidelines, ergonomic devices, such as a chair, can be recommended as an option as part of a return-to-work program for injured workers. However, there is conflicting evidence for prevention, so case-by-case recommendations are necessary. A study concluded there was no good-quality evidence on the effectiveness of ergonomics or modification of risk factors in prevention of low blood pressure. On the other hand, for improved return-to-work outcomes after an injury has occurred, there is evidence supporting ergonomic interventions. After review of the documentation, as well as the Official Disability Guidelines concerning ergonomic intervention there is no conclusive

evidence-based studies that give enough supporting evidence to necessitate the need for this device. Therefore, the request is not medically necessary.

Psychotherapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cognitive Behavioral Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 101-102.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, psychological treatment is recommended for appropriately identified patients, during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). After review of the medical documentation provided there are no current physical exam findings, subjective complaints, or current diagnoses associated with any mental health disorder. Therefore, the request is not medically necessary.

8 hours of help, once per week for cleaning home: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. After review of the medical documentation provided the injured worker does not meet the criteria listed in the guidelines. The injured worker is not homebound. Therefore, the request is not medically necessary.