

Case Number:	CM14-0039329		
Date Assigned:	08/01/2014	Date of Injury:	12/12/2006
Decision Date:	09/12/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	04/03/2014

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 58-year-old female who has submitted a claim for paraparesis, lumbar spinal stenosis, spinal cord injury, L5 radiculopathy, chronic low back pain, and gait and balance dysfunction associated with an industrial injury date of 12/12/2006. Medical records from 2013 to 2014 were reviewed. Patient complained of low back pain radiating to the right knee and left toes. Patient reported that Lyrica provided her symptom relief. Physical examination of the lumbar spine showed tenderness. Motor strength was 4 to 4+/5 at the left lower extremity, and fair to plus strength at the right leg. Sensation was diminished at the lateral aspect of bilateral lower extremities. Muscle atrophy was evident at the left thigh. Patient needed minimal assist to stand. She was able to walk with a front-wheeled walker with dragging of the left lower extremity. Treatment to date has included lumbar decompression and fusion, use of a transcutaneous electrical nerve stimulation (TENS) unit, physical therapy, electric acupuncture, and medications such as Voltaren gel, Protonix, Lyrica, Lidoderm patch, Norco, and Remeron. Utilization review from 03/12/2014 denied the request for transportation to church once a week and as needed because there was no clear evidence of extenuating circumstances which prevented the patient from obtaining transportation from individual or accessing community transportation; modified the request for physical therapy including aqua therapy and cycling 3 times 8 weeks; total 24 sessions into 6 sessions because additional sessions would depend on evidence of objective and functional improvement; denied Voltaren gel 1% 100gm with 5 refills because there was no failure of oral NSAID intake; denied Protonix 40mg #60 with 5 refills because of absence of gastrointestinal complaints; denied Lidoderm patch #1 box with 5 refills because of no evidence of failure of first-line therapy; denied Norco 10/325mg #100 with 5 refills because of no documentation of MTUS opioid compliance; denied Remeron 15mg #60 with 5 refills and Lyrica #90 with 5 refills into no refills for both to allow opportunity for

submission of medication compliance guidelines; denied electric acupuncture 2 times 8, total of 16 sessions because of no documentation regarding previous sessions; denied Diapers #60 monthly with 2 refills and alcohol swabs #4 boxes because it did not provide medical management of symptoms; and denied caregiver services 6 hours a day, 7 days a week for 8 weeks because there was limited information submitted that described patient's home situation and living environment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transportation to church once a week and as needed: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Worker's Compensation, Knee and Leg procedure Summary (updated 1/9/2013).

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, Transportation (To and From Appointments).

Decision rationale: The Official Disability Guidelines (ODG) states that transportation is recommended for medically necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. In this case, physical examination showed that patient needed minimal assist to stand, but she was able to walk with a front-wheeled walker with dragging of the left lower extremity. However, there was no discussion that patient was unable to ride public transportation or a personal car operated by another individual. The present request likewise failed to specify a limited duration of time necessitating such service. The medical necessity cannot be established due to insufficient information. Therefore, the request for transportation to church once a week and as needed is not medically necessary.

Physical therapy including aqua therapy and cycling 3 times 8 weeks; total 24 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy and Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: As stated on pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. In this case, patient previously underwent a course of physical therapy. However, the exact number of visits completed and functional outcomes were not documented. There was no objective evidence of overall pain improvement and functional gains derived from the treatment. There is likewise no discussion

why water-based therapy should be appropriate for the patient. The medical necessity cannot be established due to insufficient information. Therefore, the request for Physical therapy including aqua therapy and cycling 3x8 weeks; total 24 sessions is not medically necessary.

Voltaren gel 1% 100gm with 5 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: As stated on pages 111-112 of CA MTUS Chronic Pain Medical Treatment Guidelines, topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. Topical diclofenac is particularly indicated for osteoarthritis and tendinitis of the knee, elbow or other joints for short-term use (4-12 weeks). In this case, there was no documented rationale concerning prescription of topical diclofenac. Clinical manifestations are consistent with radiculopathy and Voltaren gel is not recommended for that particular condition as stated above. The medical necessity cannot be established due to insufficient information. Therefore, the request for Voltaren gel 1% 100gm with 5 refills is not medically necessary.

Protonix 40mg #60 with 5 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Worker's Compensation Pain Procedure Summary (updated 1/7/14), Proton Pump Inhibitors (PPIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms, and Cardiovascular Risk Page(s): 68.

Decision rationale: As stated on page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both gastrointestinal (GI) and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of (Acetylsalicylic Acid) ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should be prescribed proton pump inhibitors (PPI). In this case, there was no subjective report of heartburn, epigastric burning sensation or any other gastrointestinal symptoms that may corroborate the necessity of this medication. Furthermore, patient did not meet any of the aforementioned risk factors. The guideline criteria were not met. Therefore, the request for Protonix 40mg #60 with 5 refills is not medically necessary.

Lidoderm patch #1 box with 5 refills: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine patch Page(s): 56-57.

Decision rationale: Terocin patch contains both lidocaine and menthol. Pages 56 to 57 of CA MTUS Chronic Pain Medical Treatment Guidelines state that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or serotonin-norepinephrine reuptake inhibitor) SNRI anti-depressants or an anti-epileptic drug (AED) such as gabapentin or Lyrica). In this case, patient was initially prescribed Lyrica for neuropathic pain with temporary relief noted. Adjuvant therapy with a lidocaine patch is a reasonable treatment option at this time. Guideline criteria were met. Therefore, the request for Lidoderm patch #1 box with 5 refills is medically necessary.

Norco 10/325mg #100 with 5 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on opioid since January 2014. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Norco 10/325mg #100 with 5 refills is not medically necessary.

Remeron 15mg #60 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain.

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

Decision rationale: As stated in ODG Pain Section, pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The specific component of insomnia should be addressed in terms of sleep onset, sleep maintenance, sleep quality, and next-

day functioning. Sedating antidepressant, such as mirtazapine (Remeron), has been used to treat insomnia; however, there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. In this case, there was no documented rationale for prescribing Remeron. There was no discussion concerning sleep hygiene to warrant this medication. The medical necessity cannot be established due to insufficient information. Therefore, the request for Remeron 15mg #60 with 5 refills is not medically necessary.

Lyrica #90 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-17.

Decision rationale: As stated on pages 16 - 17 of CA MTUS Chronic Pain Medical Treatment Guidelines, antidepressants, such as pregabalin and gabapentin, are recommended as a first line option for neuropathic pain, i.e., painful polyneuropathy. In this case, the patient has been on Lyrica as early as 2013. However, there was no documentation concerning pain relief and functional improvement derived from its use. The medical necessity cannot be established due to insufficient information. The request likewise failed to specify dosage of Lyrica. Therefore, the request for Lyrica #90 with 5 refills is not medically necessary.

Electric acupuncture 2 times 8, total of 16 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: CA MTUS Acupuncture Medical Treatment Guidelines state that acupuncture is 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. Acupuncture treatments may be extended if functional improvement is documented. The frequency and duration to produce functional improvement is 3 - 6 treatments, frequency of 1 - 3 times per week, and duration of 1 - 2 months. It may be extended if functional improvement is documented. In this case, patient has received acupuncture treatment in the past; however, the exact number of visits is not documented in the medical records submitted. There was likewise no documentation stating the pain reduction, functional improvement or decreased medication-usage associated with acupuncture therapy. Therefore, the request for Electric acupuncture 2x8, total of 16 sessions is not medically necessary.

Diapers #60 monthly with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment CG-DME-10.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Section, Durable medical equipment (DME).

Decision rationale: Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Knee Section was used instead. It states that durable medical equipment (DME) is defined as a device that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. DME includes bathroom and toilet supplies, assistive devices, TENS unit, home exercise kits, cryotherapy, orthoses, cold/heat packs, etc. In this case, there is no documented rationale for diapers. It is unclear if patient has functional restrictions to require such. Moreover, diapers are not considered primarily medical in nature. The medical necessity cannot be established due to insufficient information. Therefore, the request for Diapers #60 monthly with 2 refills is not medically necessary.

Alcohol swabs #4 boxes: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment CG-DME-10.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Section, Durable medical equipment (DME).

Decision rationale: Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Knee Section was used instead. It states that durable medical equipment (DME) is defined as a device that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. DME includes bathroom and toilet supplies, assistive devices, TENS unit, home exercise kits, cryotherapy, orthoses, cold/heat packs, etc. In this case, there is no documented rationale for alcohol swabs. Moreover, it is not considered primarily medical in nature. The medical necessity cannot be established due to insufficient information. Therefore, the request for Alcohol swabs #4 boxes is not medically necessary.

Caregiver services 6 hours a day, 7 days a week for 8 weeks: 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: As stated on page 51 of CA MTUS Chronic Pain Medical Treatment Guidelines, home health services are only recommended for otherwise recommended medical treatment for patients who are homebound, 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. In this case, patient has received caregiver services for 5 hours per day times 7 days. The documented rationale for extension is to assist patient in bathing, dressing, transferring, exercising, cleaning, hair care, meal preparation, doing grocery and laundry. However, as recommended by the guidelines stated above, home health services should not include personal care and homemaker services. There is no clear indication in the medical records provided that the patient has a need of professional nursing services for the purposes of home health. Furthermore, the present request exceeded guideline recommendation of no more than 35 hours per week. Therefore, the request for Caregiver services 6 hours a day, 7 days a week for 8 weeks is not medically necessary.