MAXIMUS Federal Services

Case Number:	CM14-0079292		
Date Assigned:	08/08/2014	Date of Injury:	10/08/2006
Decision Date:	09/19/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/29/2014

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, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Ohio. 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 63-year-old male, who reported an injury on 10/08/2006. The mechanism of injury was not stated. Current diagnoses include cervicalgia, chronic pain syndrome, cervical spondylosis with myelopathy, thoracic spondylosis without myelopathy, lumbosacral spondylosis without myelopathy, cervicalgia, lumbago, thoracic pain, osteoarthrosis, carpal tunnel syndrome, and shoulder pain. The injured worker was evaluated on 08/11/2014 with complaints of persistent pain. Previous conservative treatment includes acupuncture and medication management. The current medication regimen includes Colace, Naprosyn, Lexapro, Ultram, Amitiza, Robaxin, tramadol ER, Ambien, Anusol, Norco, and trazodone. Physical examination revealed no acute distress, painful range of motion of the bilateral shoulders, paraspinal muscle tenderness in the cervical spine, decreased cervical range of motion, negative Spurling's maneuver, and decreased lumbar range of motion. Treatment recommendations at that time included continuation of the current medication regimen, 9 additional sessions of acupuncture, and chiropractic treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractor 12 Session (Unspecified Frequency): 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 Page(s): 58.

Decision rationale: MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the spine is recommended as a therapeutic trial of 6 visits over 2 weeks. Therefore, the current request for 12 sessions of chiropractic therapy exceeds guideline recommendations. There was also no specific body part listed in the request. As such, the request is not medically necessary.

Orthopedic Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. The medical rationale for an orthopedic surgeon referral has not been established. There is no documentation of any red flags for serious pathology that may require surgical intervention. The specific body part was not listed in the request. Based on the clinical information received, the request is not medically necessary.

Durable Medical Equipment (DME) -TENS Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home based trial may be considered as a noninvasive conservative option. There is no documentation of a failure to respond to other appropriate pain modalities. There is no documentation of a successful 1 month trial prior to the request for a unit purchase. As such, the request is not medically necessary.

Amitiza 8 Mg (Unspecified Strength) with 3 Refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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: www.nlm.nih.gov. U.S. National Library of Medicine. U.S. Department of Health and Human Services National Institutes of Health. Updated: 21 Aug 2014.

Decision rationale: According to The U.S. National Library of Medicine, Amitiza is used to relieve stomach pain, bloating, and straining and produce softer and more frequent bowel movements in patients with chronic idiopathic constipation. The injured worker does not maintain a diagnosis of chronic idiopathic constipation. It is also noted that the injured worker is currently utilizing Colace 100 mg. The medical necessity for the requested medication has not been established. There is also no frequency or quantity listed in the request. As such, the request is not medically necessary.

Methocarbamol 500Mg # 90 with 3 Refills: 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 Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Efficacy appears to diminish over time, and prolonged use may lead to dependence. The injured worker has continuously utilized this medication since 04/2014 without any evidence of objective functional improvement. The injured worker continues to present with paraspinal muscle tenderness and tightness in the cervical spine. There is also no frequency listed in the request. As such, the request is not medically necessary.

Tramadol HCL ER 200mg #30 with 3 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized this medication since 03/2014 without any evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Trazadone 50 Mg with 3 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.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Trazodone.

Decision rationale: California MTUS Guidelines state antidepressants are recommended for neuropathic pain and as a possibility for non-neuropathic pain. The Official Disability Guidelines recommend trazodone as an option for insomnia only for patients with potentially coexisting mild psychiatric symptoms, such as depression or anxiety. The injured worker has continuously utilized this medication since 03/2014. However, the injured worker does not maintain a diagnosis of anxiety, depression, or insomnia. The medical necessity has not been established. There is also no frequency or quantity listed in the request. As such, the request is not medically necessary.