MAXIMUS Federal Services

Case Number:	CM15-0100566		
Date Assigned:	06/03/2015	Date of Injury:	01/12/2012
Decision Date:	09/23/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	05/26/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 female, who sustained an industrial injury on January 12, 2012. She reported neck pain, low back pain, bilateral knee pain and bilateral shoulder pain. The injured worker was diagnosed as having discogenic lumbar condition with magnetic resonance imaging (MRI) revealing degenerative disc disease, facet changes and spondylolisthesis, negative nerve studies, impingement syndrome of the bilateral shoulders with MRI revealing bilateral tendinosis, bicipital tendonitis and AC joint wear, internal derangement of the bilateral knees with abnormalities noted on bilateral knee MRI studies, chronic pain, weight gain, depression, sexual dysfunction, headaches, gastrointestinal irritation and temporomandibular joint syndrome and trochanteric bursitis of the right hip. Treatment to date has included diagnostic studies, radiographic imaging, electrodiagnostic studies, medications, back and knee orthotics and work restrictions. Currently, the injured worker complains of continued neck pain, low back pain, bilateral knee pain and bilateral shoulder pain. The injured worker reported an industrial injury in 2012, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on March 25, 2015, revealed continued pain as noted. She reported gastrointestinal irritation, severe depression, sexual dysfunction, anxiety and insomnia as well. Surgical intervention of the right knee and chiropractic care was previously recommended however noted to not be covered and was not performed. She was noted to wear a back brace and knee braces. The physician noted she had previous injection to one of the knees and six physical therapy visits without benefit. She reported having a two lead TENS unit however it was noted to be too weak. Cervical traction was also recommended however there

was conflicting information on whether or not the neck was part of the industrial injury. Evaluation on June 10, 2015, revealed continued complaints as noted. Surgical intervention and coverage of the neck were still pending. Medications were adjusted and renewed. Medications, physical therapy to the left knee, a TENS unit and a conductive garment were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg (Rx 04/30/15), QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-81. Decision based on Non-MTUS Citation DEA Subchapter I - Control and Enforcement, Part C.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain Criteria For Use Of Opioids Page(s): 60, 61, 76-78, 88, 89.

Decision rationale: The patient presents with pain in low back, both knees, and both shoulders. The request is for Norco 10/325mg (Rx 04/30/15), qty: 60. The request for authorization is not provided. MRI of the shoulders showed tendinosis as well as bicipital tendonitis; and AC joint wear on the left side as well. MRI of the knees showed a grade II tear in the meniscus on the right and a grade III tear in the medial meniscus on the LEFT. MRI of the lumbar spine showed spondylolisthesis at L5-S1.Physical examination reveals knee range of motion is reduced. Positive McMurray test medially and laterally, especially on the LEFT. Impingement sign is positive bilaterally. She has had six weeks of therapy with no improvement. Patient's medications include Norco, Remeron and Neurontin. Per progress report dated 06/10/15, the patient is on modified work. MTUS Guidelines, pages 88 and 89, state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS p77 states, "Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs." The treater does not specifically discuss this medication. Patient has been prescribed Norco since at least 11/26/14. MTUS requires appropriate discussion of the 4 A's, however, in addressing the 4 A's, treater does not discuss how Norco significantly improves patient's activities of daily living with specific examples of ADL's. Analgesia is not discussed, specifically showing pain reduction with use of Norco. No validated instrument is used to show functional improvement. There is no documentation or discussion regarding adverse effects and aberrant drug behavior. A UDS date 04/30/15, but no cures or opioid contract is provided for review. Given the lack of documentation as required by MTUS, the request does not meet guidelines indication for Norco. Therefore, the request is not medically necessary.

Flexeril 7.5mg (Rx 04/30/15), QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: The patient presents with pain in low back, both knees, and both shoulders. The request is for Flexeril 7.5mg (Rx 04/30/15), qty: 60. The request for authorization is not provided. MRI of the shoulders showed tendinosis as well as bicipital tendonitis; and AC joint wear on the left side as well MRI of the knees showed a grade II tear in the meniscus on the right and a grade III tear in the medial meniscus on the LEFT. MRI of the lumbar spine showed spondylolisthesis at L5-S1. Physical examination reveals knee range of motion is reduced. Positive McMurray test medially and laterally, especially on the LEFT. Impingement sign is positive bilaterally. She has had six weeks of therapy with no improvement. Patient's medications include Norco, Remeron and Neurontin. Per progress report dated 06/10/15, the patient is on modified work. MTUS pg 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and relaxant effects. The treater does not specifically discuss this medication. The patient has been prescribed Flexeril since at least 11/26/14. However, MTUS only recommends short-term use (no more than 2-3 weeks) for sedating muscle relaxants. The request for additional Flexeril Qty: 60 would exceed MTUS recommendation and does not indicate intended short-term use. Therefore, the request is not medically necessary.

Left Knee cortisone injection, QTY: 1: 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), Knee & Leg (Acute & Chronic), and Corticosteroid injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Guidelines, Knee & Leg (Acute & Chronic) Chapter, under Corticosteroid injections.

Decision rationale: The patient presents with pain in low back, both knees, and both shoulders. The request is for left knee cortisone injection, qty: 1. the request for authorization is not provided. MRI of the shoulders showed tendinosis as well as bicipital tendonitis; and AC joint wear on the left side as well. MRI of the knees showed a grade II tear in the meniscus on the right and a grade III tear in the medial meniscus on the LEFT. MRI of the lumbar spine showed

spondylolisthesis at L5-S1. Physical examination reveals knee range of motion is reduced. Positive McMurray test medially and laterally, especially on the LEFT. Impingement sign is positive bilaterally. She has had six weeks of therapy with no improvement. Patient's medications include Norco, Remeron and Neurontin. Per progress report dated 06/10/15, the patient is on modified work. ODG Guidelines, Knee & Leg (Acute & Chronic) Chapter, under Corticosteroid injections states, "Recommended for short-term use only. Intra-articular corticosteroid injection results in clinically and statistically significant reduction in osteoarthritic knee pain 1 week after injection. Criteria for Intraarticular glucocorticosteroid injections: Documented symptomatic severe osteoarthritis of the knee... Not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen); Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease... Only one injection should be scheduled to start, rather than a series of three. A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response. With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option. The number of injections should be limited to three." Per progress report dated 04/30/15, treater's reason for the request is "to go with the lines of Utilization Review." MRI of the knees showed a grade II tear in the meniscus on the right and a grade III tear in the medial meniscus on the LEFT. Review of provided medical records show the patient previously underwent a prior Cortisone Knee Injection. Per progress report dated 04/30/15, treater states, The patient has had only one cortisone injection which did not help matters and does not recall which knee it was and does not want any cortisone injection at this point. In this case, it appears the patient is not interested in a repeat Left Knee Cortisone Injection. Be that as it may, ODG does not recommend a second injection if there has been no response from the initial injection. Therefore, the request is not medically necessary.

4-lead TENS unit, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116.

Decision rationale: The patient presents with pain in low back, both knees, and both shoulders. The request is for 4-lead tens unit, qty: 1. the request for authorization is not provided. MRI of the shoulders showed tendinosis as well as bicipital tendonitis; and AC joint wear on the left side as well. MRI of the knees showed a grade II tear in the meniscus on the right and a grade III tear in the medial meniscus on the left. MRI of the lumbar spine showed spondylolisthesis at L5-S1. Physical examination reveals knee range of motion is reduced. Positive McMurray test medially and laterally, especially on the left. Impingement sign is positive bilaterally. She has had six weeks of therapy with no improvement. Patient's medications include Norco, Remeron and Neurontin. Per progress report dated 06/10/15, the patient is on modified work. According to MTUS Chronic Pain Management Guidelines the criteria for use of tens in chronic intractable pain (p116) "a one month trial period of the tens unit should be documented (as an adjunct to other treatment modalities within a functional restoration approach) with documentation of how

often the unit was used, as well as outcomes in terms of pain relief and function during this trial." Per progress report dated 04/30/15, treater's reason for the request is "She has a two-lead tens unit and the patient needs a stronger one at this time as well." Treater does not specify if this request is for a rental or a purchase. Additionally, the patient does not present with a diagnosis indicated for the use of tens. MTUS recommends tens for neuropathic pain, CRPS, Multiple Sclerosis, Phantom pain, and spasticity pain. Furthermore, the treater does not indicate how the unit is being used, how often and with what effectiveness in terms of not only pain relief but of functional improvement. MTUS requires documentation of use of tens, as an adjunct to other treatment modalities, within a functional restoration approach. This request does not meet guidelines indication for a 4-Lead tens Unit. Therefore, the request is not medically necessary.

Conductive garment, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116.

Decision rationale: The patient presents with pain in low back, both knees, and both shoulders. The request is for conductive garment, qty: 1. the request for authorization is not provided. MRI of the shoulders showed tendinosis as well as bicipital tendonitis; and AC joint wear on the left side as well. MRI of the knees showed a grade II tear in the meniscus on the right and a grade III tear in the medial meniscus on the left. MRI of the lumbar spine showed spondylolisthesis at L5-S1. Physical examination reveals knee range of motion is reduced. Positive McMurray test medially and laterally, especially on the left. Impingement sign is positive bilaterally. She has had six weeks of therapy with no improvement. Patient's medications include Norco, Remeron and Neurontin. Per progress report dated 06/10/15, the patient is on modified work. According to MTUS Chronic Pain Management Guidelines the criteria for use of tens in chronic intractable pain (p116) "a one month trial period of the tens unit should be documented (as an adjunct to other treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function during this trial." Treater does not discuss the request. It appears the request is for a Conductive Garment to be used with the tens Unit. However, the tens Unit has not been authorized. Therefore, the request is not medically necessary.

Physical therapy to the left knee, QTY: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement measures; Physical Medicine Page(s): 48, 98-99.

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

Decision rationale: The patient presents with pain in low back, both knees, and both shoulders. The request is for physical therapy to the left knee, qty: 12. The request for authorization is not

provided. MRI of the shoulders showed tendinosis as well as bicipital tendonitis; and AC joint wear on the left side as well. MRI of the knees showed a grade II tear in the meniscus on the right and a grade III tear in the medial meniscus on the left. MRI of the lumbar spine showed spondylolisthesis at L5-S1. Physical examination reveals knee range of motion is reduced. Positive McMurray test medially and laterally, especially on the left. Impingement sign is positive bilaterally. She has had six weeks of therapy with no improvement. Patient's medications include Norco, Remeron and Neurontin. Per progress report dated 06/10/15, the patient is on modified work. MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Per progress report dated 04/30/15, treater's reason for the request is "If you wish her to have more therapy beyond the six weeks, kindly authorize 12 sessions of therapy. If not states so, so we can proceed to the surgery." Given the patient's condition, a short course of physical therapy would be indicated. However, the treater does not discuss any flare-ups, explain why on-going therapy is needed, or reason the patient is unable to transition into a home exercise program. Additionally, the patient has already attended previous sessions of physical therapy. In this case, the request for 12 additional sessions of physical therapy would exceed what is recommended by MTUS for non post-op conditions. Therefore, the request is not medically necessary.