

Case Number:	CM15-0102131		
Date Assigned:	06/09/2015	Date of Injury:	04/22/1992
Decision Date:	07/10/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	05/27/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 53 year old male, who sustained an industrial injury on April 22, 1992. Treatment to date has included physical therapy, chiropractic therapy, and medications. Currently, the injured worker complains of pain along the lumbar spine with spasm. X-rays of the lumbar and thoracic spine in March, 2015 revealed retrolisthesis of L2 on L3 and a mild loss of vertebral height at T11 and T12. He reports aching along the lower extremities and has limitations in pushing, pulling and lifting, pivoting and twisting. The diagnoses associated with the request include compression fracture of L2, low back pain, cervical pain with radiculopathy, and thoracic pain. The treatment plan includes NCV/EMG of the lower extremities, MRI of the lumbar spine, hot/cold wrap, four-lead TENS unit, neck traction with air bladder and neck pillow, Celebrex, AcipHex, Tramadol ER, Fioricet, Maxalt, and laboratory testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical traction with air bladder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 8 Neck and Upper Back Complaints Page(s): 79, 173.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cervical traction.

Decision rationale: The ODG states that cervical traction is recommended for patients with cervical radicular symptoms. Studies have demonstrated that home cervical traction can provide symptomatic relief in over 80% of patients with mild to moderately severe (Grade 3) cervical spinal syndrome with radicular symptoms. The ODG recommends home cervical auto-traction (patient-controlled), but not powered traction devices. It is recommended that cervical traction be used in conjunction with a home exercise program. In this case, the patient's injury is 20 years old. There is no information documented about symptoms related to the cervical spine. Without a medical evaluation to support any subjective complaints of neck pain, there is no indication as to the medical necessity for cervical traction. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Cervical pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine.

Decision rationale: A cervical pillow is used for neck support while sleeping. In this case, the patient's injury is 20 years old. There is no information documented about symptoms related to the cervical spine. Without a medical evaluation to support any subjective complaints of neck pain, there is no indication as to the medical necessity for a cervical pillow. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Four lead TENS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

Decision rationale: According to the MTUS guidelines, the TENS unit is not recommended as a primary treatment modality. A one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for conditions such as, neuropathic pain, phantom limb pain, complex regional pain syndrome (CRPS), spasticity or multiple sclerosis. In this case, there is lack of any medical evaluation or information to suggest that the patient has significant pain limiting his activities. Medical necessity for the requested item has not been established. The requested four-lead TENS unit is not medically necessary.

Hot and cold wrap: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 13th edition (web 2015); Neck and Upper Back (Acute & Chronic); www.odg-twc.com.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine.

Decision rationale: After review of the literature, the home application of hot/cold packs is just as effective as those performed by a therapist. In this case, the patient's injury is 20 years old. There is no information documented about symptoms related to the cervical, thoracic or lumbar spine. There is no specific indication for hot or cold wrap therapy. A hot/cold wrap is not-supported for the management of this patient's cited injuries/condition. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

EMG/NCV to Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 12 Low Back Complaints Page(s): 79, 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve conduction velocity testing.

Decision rationale: There is no documentation provided necessitating EMG testing of both lower extremities. According to the ODG, EMG (Electromyography) and nerve conduction studies are an extension of the physical examination. They can be useful in adding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies, radiculopathies, and muscle disorders. According to ACOEM Guidelines, needle EMG and H-reflex tests to clarify nerve root dysfunction are recommended for the treatment of low back disorders. In this case, there is no indication of deterioration in the patient's condition. Medical necessity for the requested studies has not been established. The requested studies are not medically necessary.

MRI Lumbar without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 13th edition (web 2015), Low Back-Lumbar and Thoracic (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MRI Lumbar spine Page(s): 304.

Decision rationale: According to California MTUS Guidelines, MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication or rationale for an MRI of the lumbar spine. There are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no new neurologic findings on physical exam. Therefore, medical necessity for the requested MRI has not been established. The requested imaging study is not medically necessary.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids.

Decision rationale: According to the California MTUS, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. In this case, it is not clear what other medications/opiates have been tried. Tramadol is not recommended as a first-line oral analgesic. Medical necessity for the requested medication has not been established. The requested treatment with Tramadol is not medically necessary.

Fioricet #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Non-barbiturate analgesic agents (BCAs).

Decision rationale: 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. Fioricet contains butalbital, acetaminophen and caffeine. It is recommended to be used less than 10 days/month. In this case, there is no documentation of the efficacy of this medication. Medical necessity for the requested medication has not been established. Of note, discontinuation of this medication should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Celebrex generic form 200mg: 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 NSAIDs Page(s): 30. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Celebrex (Celecoxib) is a nonsteroidal anti-inflammatory drug (NSAID) that is a COX-2 selective inhibitor, a drug that directly targets COX-2, an enzyme responsible for inflammation and pain. Unlike other NSAIDs, Celebrex does not appear to interfere with the antiplatelet activity of aspirin and is bleeding neutral when patients are being considered for surgical intervention or interventional pain procedures. Celebrex may be considered if the patient has a risk of GI complications, but not for the majority of patients. Generic NSAIDs and COX-2 inhibitors have similar efficacy and risks when used for less than 3 months. In this case, there is no documentation for the need for medication. The medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Aciphex 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

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

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Aciphex (Rabeprazole), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. According to the ODG, a trial of omeprazole or lansoprazole had been recommended before prescription Nexium therapy (before it went OTC). Other PPIs, such as Aciphex, should be second-line. In this case, there is no documentation indicating the patient has any GI symptoms or GI risk factors. Based on the available information provided for review, the medical necessity for Aciphex has not been established. The requested medication is not medically necessary.

Maxalt 10mg #12: 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 Medscape Internal Medicine.

Decision rationale: Rizatriptan (Maxalt) is a 5-HT₁ receptor agonist of the triptan class. It is indicated for the treatment of migraine headaches. In this case, there is no documentation of headaches. Therefore, medical necessity for the requested medication has not been established. The requested medication is not medically necessary.