MAXIMUS Federal Services

Case Number:	CM15-0102929		
Date Assigned:	06/05/2015	Date of Injury:	08/29/2003
Decision Date:	07/08/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/28/2015

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 51 year old female, who sustained an industrial injury on August 29, 2003. She reported low back pain, neck pain, bilateral shoulder pain and bilateral wrist pain. The injured worker was diagnosed as having musculoligamentous sprain of the cervical spine with upper extremity radiculitis, cervical disc bulges. Overuse syndrome of the bilateral upper extremities, internal derangement of the bilateral shoulders, cubital tunnel syndrome of the right elbow, lateral epicondyliyis of the right elbow, medical epicondylitis of the right elbow, De Quervain's tendinitis of the bilateral wrists, carpal tunnel syndrome of the bilateral wrists, musculoligamentous sprain of the lumbar spine with lower extremity radiculitis, cervical disc bulge osteophyte complex (noted on magnetic resonance imaging of the cervical spine on January 21, 2014), possible glenoid labrum tear of the right shoulder and acromioclavicular joint osteoarthritis of the right shoulder . Treatment to date has included radiographic imaging, diagnostic studies, conservative care, home cervical traction, medications and work restrictions. Currently, the injured worker complains of continued neck pain radiating to bilateral shoulders and upper extremities with associated pain, tingling and numbness and low back pain with pain, tingling and numbness radiating to bilateral lower extremities. The injured worker reported an industrial injury in 2003, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on April 29, 2015, revealed continued pain as noted with associated symptoms. Chiropractic care, acupuncture, physical therapy, continuing home cervical traction and medications and an electrodiagnostic study of the bilateral upper extremities were recommended. Chiropractic care, acupuncture, physical therapy and medications were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin #60, one BID with four refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The records do not document that the patient has neuropathic pain related to her chronic low back condition. In this case, there was no documentation of subjective or objective findings consistent with current neuropathic pain to necessitate use of Neurontin. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

Diclofenac potassium 50mg #60 with one BID with five (5) refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71.

Decision rationale: According to California MTUS Guidelines, oral NSAIDs, such as Diclofenac, are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), and short-term pain relief in chronic LBP. There is no evidence of long-term effectiveness for pain or function. According to the ODG, there is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain in this condition. Physicians should measure transaminases periodically in patients receiving long-term therapy with Diclofenac. In this case, there is no documentation of functional benefit in the past. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

Omeprazole 20mg #30, one daily with five (5) refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age >65, history

of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. There is no documentation indicating that this patient has had any GI symptoms or risk factors. Based on the available information provided for review, the patient has not been maintained on NSAIDs. The medical necessity for Omeprazole has not been established. The requested medication is not medically necessary.

Acupuncture two (2) times per week for ten (10) sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the Acupuncture Medical Treatment Guidelines, 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 recovery. The treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions over no more than two weeks. If functional improvement is documented, as defined by the guidelines further treatment will be considered. In this case, there is documentation of previous acupuncture visits, however, there is no documentation of objective improvement with previous treatments. Medical necessity for additional acupuncture sessions has not been established. The requested acupuncture treatments are not medically necessary.

Physical therapy two (2) times per week for ten (10) sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient had previous PT sessions but there is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the additional 10 PT (2x5) sessions requested. Medical necessity for the additional PT visits requested has not been established. The requested services are not medically necessary.

Chiropractic two (2) times per week for ten (10) sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chiropractic Manipulation.

Decision rationale: According to MTUS, Manual Therapy or Chiropractic therapy, is recommended for chronic pain if it is caused by musculoskeletal conditions. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the treatment of low back pain, a trial of 6 visits is recommended over 2 weeks, with evidence of objective improvement, with a total of up to 18 visits over 6-8 weeks. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In this case, there is no documentation of the previous number of chiropractic sessions completed or functional improvement with previous chiropractic therapy. Medical necessity for the requested service has not been established. The requested chiropractic therapy is not medically necessary.