MAXIMUS Federal Services

Case Number:	CM15-0106983		
Date Assigned:	06/11/2015	Date of Injury:	09/30/2013
Decision Date:	08/24/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/03/2015

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: Texas, Illinois
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 52 year old male, who sustained an industrial injury on 09/30/2013. He has reported subsequent low back and bilateral hip pain and was diagnosed with lumbosacral sprain/strain, lumbosacral radiculitis of the left side, herniated nucleus pulposus of the lumbar spine and bilateral hip sprain/strain. Treatment to date has included oral and topical pain medication, home exercise program, application of heat and cold and surgery. In a progress note dated 07/18/2014, the injured worker complained of continued low back and bilateral hip pain that was rated as 7/10. Objective findings were notable for decreased range of motion of the lumbar spine with tenderness over the paraspinal muscles, left greater than right, positive bilateral Kemp's sign, positive straight leg raise on the left at 60 degrees and the right at 70 degrees, tenderness over the iliac crest bilaterally with decreased range of motion and positive Patrick's sign. A request for authorization of Tylenol #3, Voltaren gel, chiropractic therapy 2x3 of the lumbar spine and urine toxicology screen was submitted. There was no medical documentation submitted that pertains to the current treatment request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol No. 3 (Codeine 30/Acetaminophen 300) #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-88.

Decision rationale: The injured worker sustained a work related injury on 09/30/2013. The medical records provided indicate the diagnosis of lumbosacral sprain/strain, lumbosacral radiculitis of the left side, herniated nucleus pulposus of the lumbar spine and bilateral hip sprain/strain. Treatment to date has included oral and topical pain medication, home exercise program, application of heat and cold and surgery. The medical records provided for review do indicate a medical necessity for Tylenol No. 3 (Codeine 30/Acetaminophen 300) #90. The MTUS recommends the use of the lowest dose of opioids for the short-term treatment of moderate to severe pain. The MTUS states that a written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education. The MTUS recommends that individuals on opioid maintenance treatment be monitored for analgesia (pain control), activities of daily living, adverse effects and aberrant behavior; to discontinue opioid treatment if there is no documented evidence of overall improvement (the MTUS defines functional improvement either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management) or if there is evidence of illegal activity or drug abuse or adverse effect with the opioid medication. The medical records indicate the injured worker suffers from uncontrollable hypertension when treated with NSAIDs; the injured worker has significant improvement in pain and function with the use of medications(the pain subsides from 7/10 to 4/10 with medication; and the workers walking improves from 20 minutes to 40 minutes).

Voltaren gel 1% 100 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: The injured worker sustained a work related injury on 09/30/2013. The medical records provided indicate the diagnosis of lumbosacral sprain/strain, lumbosacral radiculitis of the left side, herniated nucleus pulposus of the lumbar spine and bilateral hip sprain/strain. Treatment to date has included oral and topical pain medication, home exercise program, application of heat and cold and surgery. The medical records provided for review do not indicate a medical necessity for Voltaren gel 1% 100 gm. Voltaren gel is a topical analgesic. The topical analgesics are largely experimental drugs primarily recommended for neuropathic pain that has failed treatment with the first line antidepressant and anticonvulsants. Voltaren (diclofenac) is an NSAID containing topical analgesic Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. This medication is not

medically necessary, because there is no indication the injured worker has failed treatment with anti-depressants and anti-convulsants. Also, the injured worker's condition is in the spine, not the ankle, elbow, foot, hand, knee, and wrist, where topical NSAID analgesics have been found useful.

Chiropractic therapy 2x3, lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation; Physical Medicine Page(s): 58-59; 98-99.

Decision rationale: The injured worker sustained a work related injury on 09/30/2013. The medical records provided indicate the diagnosis of lumbosacral sprain/strain, lumbosacral radiculitis of the left side, herniated nucleus pulposus of the lumbar spine and bilateral hip sprain/strain. Treatment to date has included oral and topical pain medication, home exercise program, application of heat and cold and surgery. The medical records provided for review do not indicate a medical necessity for Chiropractic therapy 2x3, lumbar spine. The MTUS discusses chiropractic care under manipulation and manual therapy; and physical therapy. The manual therapy guidelines recommends trial of 6 visits of therapeutic care over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care. Not medically necessary. Recurrences/flare-ups. Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. The Physical Medicine Guidelines, used for active chiropractic care recommends a maximum of 10 visits. According to the utilization review document, the injured worker was approved of 8 visits of chiropractic care in 05/15. Therefore, the additional request exceeds the recommended 10 visits using the physical medicine physical therapy guidelines. For the Manual therapy Guidelines, one cannot determine whether the injured worker needs extension of care without knowing the outcome of the previously approved treatment.

Urine toxicology screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Urine drug testing (UDT).

Decision rationale: The injured worker sustained a work related injury on 09/30/2013. The medical records provided indicate the diagnosis of lumbosacral sprain/strain, lumbosacral radiculitis of the left side, herniated nucleus pulposus of the lumbar spine and bilateral hip sprain/strain. Treatment to date has included oral and topical pain medication, home exercise program, application of heat and cold and surgery. The medical records provided for review do not indicate a medical necessity for: Urine toxicology screen. The MTUS recommends the use of urine drug screen an option to assess for the use or the presence of illegal drugs.

The Official Disability Guidelines recommends that individuals at low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. The medical records indicate the injured worker is at low risk of addiction/ aberrant behavior; the injured worker was tested in 04/2015. Therefore, a repeat test is not medically necessary at this time.