

Case Number:	CM15-0107340		
Date Assigned:	06/11/2015	Date of Injury:	11/16/2011
Decision Date:	08/18/2015	UR Denial Date:	05/20/2015
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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 58 year old female, who sustained an industrial injury on 11/16/2011. She has reported subsequent low back and lower extremity pain and was diagnosed with musculoligamentous sprain/strain of the lumbar spine, lumbosacral instability and lumbar radiculopathy. Treatment to date has included oral and topical pain medication. In a progress note dated 05/04/2015, the injured worker complained of low back, right hip and leg pain. Objective findings were notable for a moderately antalgic gait and decreased range of motion of the lumbar spine. The physician noted that it had been 2 years since the injured worker had undergone any conservative treatment. A request for authorization of Gabapentin, follow up in 3 months for the lumbar spine/right hip, chiropractic/physiotherapy plus manipulation, 3 times weekly for 4 weeks of the lumbar spine/right hip for a total of 12 sessions and TENS unit plus supplies for the lumbar spine, 6 month rental was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 100 mg Qty 90 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-21 of 127.

Decision rationale: Regarding request for gabapentin (Neurontin), Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS) and objective functional improvement. Anti-epileptic drugs should not be abruptly discontinued but unfortunately there is no provision to modify the current request. As such, the currently requested gabapentin (Neurontin) is not medically necessary.

Follow up in 3 months, Lumbar spine/Right Hip: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip & Pelvis - Office visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Office visits.

Decision rationale: Regarding the request for a follow-up visit, California MTUS does not specifically address the issue. ODG cites that "the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring." The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. Within the documentation available for review, while it is noted that the provider's recommendations have been determined to be not medically necessary, the patient does have ongoing pain and follow-up is appropriate so that other treatment considerations can be made. In light of the above, the currently requested follow-up visit is medically necessary.

Chiro/physiotherapy plus manipulation, 3 times wkly for 4 wks, Lumbar Spine/Right Hip, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60 of 127.

Decision rationale: Regarding the request for chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, there is documentation of completion of prior chiropractic sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In the absence of clarity regarding the above issues, the currently requested chiropractic care is not medically necessary.

TENS (transcutaneous electrical nerve stimulation) Unit plus supplies, Lumbar Spine, 6 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117 of 127.

Decision rationale: Regarding the request for TENS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial should be documented as an adjunct to ongoing 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, function, and medication usage. Within the documentation available for review, the provider notes that prior use resulted in nonspecific improvement of symptoms, but there is no documentation of how often the unit was used, as well as specific outcomes in terms of pain relief, function, and medication usage. In the absence of clarity regarding those issues, the currently requested TENS unit is not medically necessary.