MAXIMUS Federal Services

Case Number:	CM15-0167720		
Date Assigned:	09/08/2015	Date of Injury:	06/14/2010
Decision Date:	10/14/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	08/26/2015

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: 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 37-year-old male, with a reported date of injury of 06-14-2010. The mechanism of injury was the result of stumbling backwards off a ladder. The injured worker's symptoms at the time of the injury included immediate pain in the lumbar spine. The diagnoses include cervical disc displacement, cervical radiculopathy, cervical sprain and strain, thoracic sprain and strain, lumbar disc displacement, lumbar radiculopathy, lumbar sprain and strain, left rotator cuff sprain and strain, left ulnar nerve entrapment, right ulnar nerve entrapment, left carpal tunnel syndrome, and right carpal tunnel syndrome. The treatments to date have included oral medications, topical pain medication, physical therapy, acupuncture, and pain management therapy. According to the report dated 02-02-2015, the diagnostic and evaluation exams included electrodiagnostic studies of the lower extremities on 08-23-2010; an MRI of the cervical spine and lumbar spine on 12-31-2012; electrodiagnostic studies of the lower extremities on 01-25-2013; and an MRI of the thoracic spine on 03-18-2013.The progress report dated 07- 06-2015 indicates that the injured worker presented with complaints of low back pain with radiation to the bilateral legs. He also complained of thoracic spine pain, cervical spine pain, left shoulder pain, and numbness in the right wrist and left wrist. The objective findings include guarding of the right trapezius muscles; decreased cervical range of motion; sore base of the right second metacarpal bone; decreased range of motion of the left shoulder; normal bilateral wrist and elbow range of motion; positive Tinel's sign of the bilateral elbows; positive Phalen's in the right wrist; hypoesthesia in the right C6 and left C7; decreased lumbar range of motion; positive bilateral Lasegue's test; an antalgic gait; and decreased range of motion of the thoracic

spine. The injured worker underwent an MRI of the cervical spine and lumbar spine on 02-02-2015 which showed cervical strain and sprain, herniated nucleus pulposus at C3-4, lumbar strain and sprain, and SLAP tear. The treatment plan included the recommendation of Norco, Prilosec, GabaFlur compound, an epidural steroid injection of the right cervical spine and right lumbar spine, LINT (localized intense neurostimulation therapy) for the lumbar spine, subacromial injection into the left shoulder, and re-evaluation in four months. The injured worker has been instructed to return to full duty on 07-07-2015 with no limitations or restrictions. The treating physician requested Norco 10-325mg, Prilosec 20mg, compounded medication: GabaFlur cream, follow-up appointment, right cervical epidural steroid injection at C6-7, right lumbar epidural steroid injection at L4-5, six LINT therapy sessions for the lumbar spine, and subacromial injection into the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg twice a day (unknown quantity): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/ Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non- opioid therapy. There is no documentation of significant pain relief or increased function from the opioids used to date. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Prilosec 20mg 1 twice a day (unknown quantity): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic) Chapter - Proton pump inhibitors (PPIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. 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.

Compound medication: Gabapentin/Flurbiprofen cream (unknown dose and quantity): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (for example including, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics and/or antidepressants). Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic compound contains: Gabapentin and Flurbiprofen. Gabapentin is not recommended as a topical agent per CA MTUS Guidelines. Flurbiprofen, used as a topical NSAID, has been shown to be superior to placebo during the first two weeks of treatment for osteoarthritis, but either not afterward, or with diminishing effect over another two-week period. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

Epidural steroid injection to the cervical spine at the right C6-C7: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ESIs.

Decision rationale: According to the California MTUS Treatment Guidelines, epidural steroid injections are recommended as an option for the treatment of radicular pain. Criteria for use of cervical epidural steroid injections (CESI's) include radiculopathy that must be documented by physical exam and corroborated by imaging studies and/or electro-diagnostic testing. The patient should be initially unresponsive to conservative treatments such as exercise programs, physical methods, NSAIDs, and muscle relaxants. Injections should be performed using fluoroscopy for guidance. CESI's are of uncertain benefit and should be preserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. In this case, the patient has cervical radiculopathy and MRI evidence of a cervical disc protrusion at C3-C4 but, it is unclear what conservative therapy has been tried before requesting the epidural steroid injection. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Epidural steroid injection to the lumbar spine at the right L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ESIs.

Decision rationale: Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Research has shown that, on average, less than two injections are required for a successful ESI outcome. ESIs can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. The CA MTUS guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, there is evidence of lumbar radiculopathy but the provider still has not reviewed the patient's MRI studies and it is unclear what conservative therapy has been tried before requesting the epidural steroid injection. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Follow up visit: Overturned

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Shoulder Complaints 2004, and Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Follow-up Visits.

Decision rationale: The need for a clinical office visit with a health care provider is individualized based on the review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Patients with low back complaints that are work related should receive follow-up care every 3 to 5 days by a mid-level practitioner, who can counsel them about avoiding static positions, medication use, activity modification, and other concerns. Physician follow-up generally occurs when a release to modified, increased, or full duty is needed, or after appreciable healing or recovery can be expected, on average. Physician follow-up might occur every 4 to 7 days if the patient is off work, and 7 to 14 days if the patient is working. In this case, the patient has a chronic pain condition involving both the low back and neck and there is documentation of active pain and the use of pain medications to manage pain. Medical necessity for the requested follow-up visits has been established. The requested visits are medically necessary.

Localized Intensive Neurostimulation Therapy (LINT) therapy 1 time a week for 6 weeks for the lumbar spine: 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 Official Disability Guidelines (ODG) Localized Intense Neuro-stimulation Therapy (LINT).

Decision rationale: According to the ODG, Localized Intense Neuro-stimulation Therapy (LINT) or hyper-stimulation analgesia is not recommended until there are higher quality studies. Localized manual high-intensity neuro-stimulation devices are applied to small surface areas to stimulate peripheral nerve endings (A- fibers), thus causing the release of endogenous endorphins. This procedure, usually described as hyper-stimulation analgesia, has been investigated in several controlled studies. One of the oldest methods of pain relief is generalized hyper-stimulation analgesia produced by stimulating myofascial trigger points by dry needling, acupuncture, intense cold, intense heat, or chemical irritation of the skin. The moderate-to-intense sensory input of hyper-stimulation analgesia is applied to sites over or sometimes distant from, the pain. Medical necessity for the requested treatment has not been established. The request for this treatment is not medically necessary.

Subacromial injection into the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter - Steroid injections.

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

Decision rationale: The ODG recommends subacromial steroid injections for the treatment of rotator cuff disease. Corticosteroid injections may be superior to physical therapy interventions for short-term results, with a maximum of three recommended. Subacromial injections of corticosteroids are effective for improvement for rotator cuff tendinitis up to a 9-month period. They are also probably more effective than NSAID medication. A subacromial injection is helpful to distinguish between shoulder weakness caused by impingement (shoulder strength improves after injection) and true rotator cuff tear (no change in strength). In this case, it is unclear what conservative treatments have been tried and for what period of time. Medical necessity for the requested item has not been established. The requested item is not medically necessary.