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| Case Number: | CM15-0181620 | | |
| Date Assigned: | 09/22/2015 | Date of Injury: | 03/23/2009 |
| Decision Date: | 11/16/2015 | UR Denial Date: | 09/01/2015 |
| Priority: | Standard | Application Received: | 09/15/2015 |

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 49 year old male, who sustained an industrial injury on 3-23-2009. The medical records indicate that the injured worker is undergoing treatment for cervical spine herniated nucleus pulposus, lumbar herniated nucleus pulposus, status post lumbar fusion (9-4-2013), lumbar radiculopathy, depression, and gastrointestinal upset. According to the progress report dated 8-5-2015, the injured worker presented with complaints of pain in his neck (6 out of 10) and low back (8 out of 10) with radiation into left leg. He notes that his pain is better since last review. The physical examination of the cervical and lumbar spine reveals spasms, decreased range of motion, decreased sensation to light touch over the C6-7 and L5-S1 distribution, and positive straight leg raise test. The current medications are not specified. The medical records do not indicate when Percocet and Gabapentin were originally initiated. Treatments to date include medication management, physical therapy, and surgical intervention. Work status is described as temporarily totally disabled. Notes go on to state that the patient had failed to respond to aggressive physical therapy directed towards the sacroiliac joints for a period of 4 to 6 weeks in the presence of other significant low back pathology has been ruled out or previously addressed. The note goes on to state that the patient used a comprehensive exercise program without relief. The original utilization review (9-1-2015) had non-certified a request for Percocet, Gabapentin, 4 lumbar trigger point injections, and 8 physical therapy sessions to the neck and lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 7.5mg/ 325mg #120: 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 (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

Decision rationale: Regarding the request for Percocet (oxycodone/acetaminophen), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Percocet (oxycodone/acetaminophen) is not medically necessary.

8 Sessions physical therapy to neck: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM: Pain, Suffering, and the Restoration of Function, page 114 / Official Disability Guidelines (ODG): Neck and Upper Back.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of any specific objective treatment

goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In the absence of such documentation, the current request for physical therapy is not medically necessary.

8 Sessions physical therapy to lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM: Pain, Suffering, and the Restoration of Function, page 114 / Official Disability Guidelines (ODG); Low Back.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care, Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT 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. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

Gabapentin 600mg #90: 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): Antiepilepsy drugs (AEDs).

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 no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. Antiepileptic 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.

4 Lumbar trigger point injections: 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): Trigger point injections. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Trigger Point Injections.

Decision rationale: Regarding the request for trigger point injections, Chronic Pain Medical Treatment Guidelines support the use of trigger point injections after 3 months of conservative treatment provided trigger points are present on physical examination. ODG states that repeat trigger point injections may be indicated provided there is at least 50% pain relief with reduction in medication use and objective functional improvement for 6 weeks. Within the documentation available for review, there are no physical examination findings consistent with trigger points, such as a twitch response as well as referred pain upon palpation. Additionally, there is unclear documentation of failed conservative treatment (notes stating that PT has failed but also a request for additional therapy). In the absence of such documentation, the requested trigger point injections are not medically necessary.