

Case Number:	CM15-0183288		
Date Assigned:	09/24/2015	Date of Injury:	08/01/2014
Decision Date:	11/24/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/17/2015

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: Tennessee, Florida, Ohio
 Certification(s)/Specialty: Surgery, Surgical Critical Care

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 42 year old male who sustained an industrial injury August 1, 2014, after a fall, with immediate pain in his neck and back. Past history included hypertension. According to an initial orthopedic consultation dated July 30, 2015, the injured worker presented with complaints of moderate to severe neck pain, rated 7 out of 10, upper back pain rated 7 out of 10, middle and lower back pain, rated 7 out of 10, wrist pain bilateral, and bilateral heel pain. He reported numbness and tingling to the bilateral lower extremities intermittently and numbness and tingling to the upper extremities at night. He has received relief from chiropractic therapy, rest and medication. The physician documented undated radiology to include; MRI of the cervical spine reveals a 4mm herniated disc at C5-6. An MRI of the lumbar spine reveals a 2 mm herniated disc at L4-5; Electrodiagnostic studies of the bilateral upper extremities revealed moderate bilateral carpal tunnel syndrome involving the sensory fibers. Physical examination revealed; cervical spine-negative Spurling's test; bilateral wrists- negative Tinel's, Phalen's, and median nerve compression test, negative lift off test; lumbar spine-gait and posture within normal limits; walks on heels and toes; pain with lateral bend left and right; negative straight leg raise bilaterally in the seated and supine position. Assessment is documented as chronic neck pain; herniated disc cervical spine; bilateral subclinical carpal tunnel syndrome; chronic low back pain; herniated disc lumbar spine; radiculitis lower extremities. At issue, is the request for authorization for acupuncture (3) x (6) cervical spine and lumbar spine, chiropractic therapy (3) x (6), cervical spine, lumbar corset, Omeprazole 20mg #30, and TENS unit, 30 day trial. According to utilization review dated August 21, 2015, the request for Diclofenac XR

100mg #30 is certified. The request for Omeprazole 20mg #30 is non-certified. The request for chiropractic therapy cervical spine and lumbar spine (3) x (6) (18 sessions) was modified to chiropractic therapy x (6) sessions, cervical and lumbar spine. The request for a lumbar corset is non-certified. The request for a TENS (transcutaneous electrical nerve stimulation) unit 30 day trial is non-certified. The request for acupuncture (3) x (6), lumbar spine is non-certified. The request for acupuncture (3) x (6) cervical spine is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #30: 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): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of the requested prescription for this patient. The clinical records submitted do not support the fact that this patient has refractory GERD resistant to H2 blocker therapy or an active h. pylori infection. The California MTUS guidelines address the topic of proton pump prescription. In accordance with California MTUS guidelines, PPI's (Proton Pump Inhibitors) can be utilized if the patient is concomitantly on NSAIDS and if the patient has gastrointestinal risk factors. Additionally, per the Federal Drug Administration's (FDA) prescribing guidelines for PPI use, chronic use of a proton pump inhibitor is not recommended due to the risk of developing atrophic gastritis. Short-term GERD symptoms may be controlled effectively with an H2 blocker unless a specific indication for a proton pump inhibitor exists. This patient's medical records do not support that he has GERD. The patient has no documentation of why chronic PPI therapy is necessary. Therefore, based on the submitted medical documentation, the request for omeprazole prescription is not medically necessary.

TENS unit (30 day trial): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a TENS unit for this patient. The California MTUS guidelines recommend the following regarding criteria for TENS unit use: 1. Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. 2. There is evidence that other appropriate pain modalities have been tried (including medication) and failed: A one-

month trial period of the TENS unit 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 and function; rental would be preferred over purchase during this trial³. Other ongoing pain treatment should also be documented during the trial period including medication usage⁴. A treatment plan including the specific short- and long- term goals of treatment with the TENS unit should be submitted⁵. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. This patient's case does not meet the recommended criteria since no clear treatment plan (that includes short and long term goals) was submitted. Therefore, based on the submitted medical documentation, the request for TENS unit is not medically necessary.

Lumbar corset: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care, Activity, Work.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The California MTUS guidelines do not address this topic. Regarding the request for lumbar corset, ACOEM states that a sling/brace may be used for a brief period following severe lordotic pathology. However, lumbar supports are not recommended for the treatment of any of this patient's diagnosis. The requesting physician has not provided any substantial peer-reviewed scientific literature supporting the use of this treatment modality for his patient's diagnoses. Therefore, based on the submitted medical documentation, the request for a lumbar corset is not medically necessary.

Chiropractic therapy 3x6 - cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this intervention for this patient. The California MTUS Guidelines state that Chiropractic manipulation is recommended for the treatment of chronic pain that has acute flares or "requires therapeutic care." However, it is "not recommended for elective for maintenance therapy." The medical records support that this patient has chronic back pain, which has been stable with no recent flare-ups or acute interventions. The patient's pain appears to be at a steady state for which he has been receiving multiple treatment modalities. Although a trial of manipulation would not be inappropriate, 18 treatments exceeds the MTUS recommendations for treatment. MTUS does not support the need for manipulation as maintenance therapy. Therefore,

based on the submitted medical documentation, the request for 18 sessions of chiropractic therapy is not medically necessary and has not been established.

Acupuncture 3x6 - cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007. Decision based on Non-MTUS Citation ACOEM Pain, Suffering, and the Restoration of Function Chapter (page 114).

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of acupuncture testing for this patient. The California MTUS Acupuncture guidelines address the topic of neck/cervical acupuncture. In accordance with California MTUS Acupuncture guidelines "Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented." This patient has been prescribed acupuncture for q3 times for 6 weeks in 18 sessions. Based on MTUS guidelines, a trial of acupuncture is clinically appropriate but the number of sessions exceeds the MTUS recommendations for a trial of treatment. Therefore, based on the submitted medical documentation, the request for cervical acupuncture testing is not medically necessary.

Acupuncture 3x6 - lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007. Decision based on Non-MTUS Citation ACOEM Pain, Suffering, and the Restoration of Function Chapter (page 114).

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of acupuncture testing for this patient. The California MTUS Acupuncture guidelines address the topic of neck/cervical acupuncture. In accordance with California MTUS Acupuncture guidelines "Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented." This patient has been prescribed acupuncture for q3 times for 6 weeks in 18 sessions. Based on MTUS guidelines, a trial of acupuncture is clinically appropriate but the number of sessions exceeds the MTUS recommendations for a trial of treatment. Therefore, based on the submitted medical documentation, the request for lumbar acupuncture testing is not medically necessary.