

Case Number:	CM15-0184338		
Date Assigned:	09/24/2015	Date of Injury:	09/18/2014
Decision Date:	12/01/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	09/18/2015

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, California

Certification(s)/Specialty: Emergency 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:

This 43 year old man sustained an industrial injury on 9-16-2014. Evaluations include cervical spine MRI dated 12-17-2014 showing mild right uncovertebral hypertrophy, moderate bilateral hypertrophy without stenosis, and bilateral foraminal cervical stenosis and a lumbar spine MRI dated 11-7-2014 showing left lateral recess and neural foraminal disc protrusion at L5-S1, and a unilateral pars defect. Diagnoses include lumbago with bilateral radiculopathy and cervical radiculopathy and cervicgia. Treatment has included oral medications, physical therapy, and lumbar spine epidural steroid injection. Physician notes dated 8-28-2015 show complaints of constant and severe low back pain with radiation to the bilateral feet with numbness, inability to sleep at night, neck pain with radiation to the bilateral arms with numb hands, headaches that worsen with the neck pain, and ringing in the bilateral ears. The physical examination shows normal cervical spine curvature, normal range of motion, pain with cervical spine rotation, normal range of motion at the shoulders, tenderness was noted to the trapezi and posterior shoulders, Tinel's and Phalen's signs were negative. The bilateral upper extremities show full strength, normal sensory, and reflex examinations. The lumbar spine shows normal curvature, pain on extension and flexion, and normal straight leg raise. Motor and sensory exams were normal, reflexes are 2+ at the knees bilaterally and 1+ at the ankles bilaterally. The worker displays an inability to heel or toe walk. Recommendations include Tylenol, Motrin, Gabapentin, spinal surgery consultation, aquatic therapy, functional capacity evaluations, electromyogram and nerve conduction studies of the bilateral lower extremities, and follow up in six weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motrin 400mg #150 with 1 refill: 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, specific drug list & adverse effects, NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: According to CA MTUS chronic pain guidelines, non-steroidal anti-inflammatory agents are "recommended as an option for short term symptomatic relief" for the treatment of chronic low back pain. Further recommendations are for the lowest dose for a minimal duration of time. Specific recommendations for ibuprofen (Motrin) state, "sufficient clinical improvement should be observed to offset potential risk of treatment with the increase dose." The documentation does not support improvement of symptoms with NSAIDs currently prescribed. The IW has been prescribed Ibuprofen for a minimum of 10 months. This medication was discontinued in January 2015 due to epigastric complaints, but was restarted 2 months later. Additionally, the request does include frequency and dosing of this medication. Without the support of the documentation or adherence to the guidelines, the request is medically not necessary.

Tylenol 500mg #150 with 1 refill: 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): Acetaminophen.

Decision rationale: According to CaMTUS, acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Both acetaminophen and NSAIDs have been recommended as first line therapy for low back pain. There is insufficient evidence to recommend one medication over the other. Selection should be made on a case-by-case basis based on weighing efficacy vs. side effect profile. In the past, many low back pain guidelines recommended acetaminophen as a first line treatment but recent systematic reviews either failed to find evidence to support the view that acetaminophen was effective for the treatment of non-specific low back pain. It appears from the submitted documentation that acetaminophen is a new prescription for this IW. Given the IW ongoing back pain and previous stomach irritation with NSAIDs, it is reasonable for a trial of acetaminophen. However, the request does not include dosing or frequency. In addition, the request includes 1 refill. As this appears to be a new medication, the efficacy should be re-evaluated after a 1-month trial before repeat prescriptions are utilized. As such, the request for acetaminophen 500mg with 1 refill is determined not medically necessary.

Gabapentin 100mg #200 with 1 refill: 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): Anti-epilepsy drugs (AEDs).

Decision rationale: According to CA MTUS, gabapentin is an anti-epilepsy drug which has efficacy for diabetic neuropathy or post-herpetic neuropathy. It has also been considered a first line agent for neuropathic pain. There is not sufficient evidence to recommend the use of these medications for the treatment of chronic non-specific, non-neuropathic axial low back pain. Ongoing use of these medications recommends "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." The IW does not have diabetic neuropathy or post-herpetic conditions. The documentation reports improvement of pain with the use of medications, but specific responses to individual medications is not noted in the record. Additionally, the request does not include dosing frequency. Without this documentation, the request for gabapentin is not medically necessary in accordance with MTUS guidelines.

1 Spinal surgery consultation: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Examination, Surgical Considerations.

Decision rationale: According the above referenced guideline, surgical spinal referral is indicated for: "Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair; Failure of conservative treatment to resolve disabling radicular symptoms." The documentation does not include a detailed neurologic examination detailing a dermatomal distribution of deficits. The IW has actively been participating in physical therapy sessions. In addition, EMG studies included in the records reveal normal results. Without the support of the documentation, the request for a spine surgeon referral is not medically necessary.

6 Aquatic therapy sessions: 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): Aquatic therapy, Physical Medicine.

Decision rationale: According to CA MTUS guidelines, aquatic therapy is "recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity." Additional guidelines states, "patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Physical medicine recommendations allow for fading treatment frequency. Documentation supports the IW has been participating in physical therapy and has a home exercise program. Chart material does not include documentation of obesity, body mass index calculation, or compelling reason why an exercise program with reduce weight bearing is favorable for this injured worker. Without the supporting documentation, the request for aquatic therapy is determined not medically necessary.

1 Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty, Functional capacity evaluation.

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

Decision rationale: According to ODG guidelines, functional capacity evaluation is "recommended prior to admission to a work hardening program, with a preference for assessments tailored to a specific task or job. It is not recommended for routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally." The documentation does not support the IW's progress is approaching return to work status. The IW continues to report increasing pain despite multiple treatment approaches. There is no documentation of decreased reliance on medications. In fact, new analgesia medications are being trialed. The Official Disability Guidelines recommend a functional capacity evaluation for Work Hardening programs, which is not the context in this case. The treating physician has not defined the components of the functional capacity evaluation. Given that there is no formal definition of a functional capacity evaluation, and that a functional capacity evaluation might refer to a vast array of tests and procedures, medical necessity for a functional capacity evaluation, cannot be determined without a specific prescription which includes a description of the intended content of the evaluation. The request for a functional capacity evaluation is not medically necessary.

1 EMG/NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar and Thoracic (Acute and Chronic), EMG, NCS.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies.

Decision rationale: The Utilization Review non-certified an NCV because electrodiagnostic testing was ordered for a possible radiculopathy. There is no discussion in the records of any other possible cause for the leg symptoms. Per the MTUS citation, electrodiagnostic testing may be an option for persistent, non-specific, leg symptoms that accompany back pain. An EMG, not an NCV, is the test for radiculopathy. The documentation does not include a detailed neurologic examination detailing a dermatomal distribution of deficits. The IW has actively been participating in physical therapy sessions. The IW reports ongoing and increasing pain despite multiple medication trials. Without support of the guidelines or adherence to the guidelines, the request for EMG/NCV studies of the bilateral lower extremities is determined not medically necessary.