

Case Number:	CM15-0191802		
Date Assigned:	10/06/2015	Date of Injury:	04/19/2006
Decision Date:	12/14/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	09/29/2015

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: Pediatrics, Internal 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:

The injured worker is a 51 year old male who sustained an industrial injury on 04-19-2006. A review of the medical records indicated that the injured worker is undergoing treatment for multi-level disc protrusions with radiculopathy-radiculitis of the cervical spine, left elbow lateral epicondylitis, lumbar spine disc lesion and insomnia. According to the treating physician's progress report on 08-14-2015, the injured worker continues to experience neck, middle and low back pain, left shoulder and right elbow pain. The injured worker rated his neck pain at 8, low back pain at 4, middle back at 10 and left shoulder pain at 3 out of 10 on the pain scale. Examination of the cervical spine noted positive foraminal compression and Spurling's tests with range of motion documented at forward flexion 30 degrees, extension 20 degrees, right rotation 55 degrees, left rotation at 45 degrees and bilateral lateral bending at 20 degrees each. There was documented tightness and spasm in the trapezius, sternocleidomastoid and strap muscles bilaterally. Bilateral biceps and supinator reflexes were 2 plus, right triceps were 2 minus and left triceps were 2 plus. The left shoulder examination noted tenderness over the left rotator cuff muscles and the greater tuberosity of the left humerus with subacromial grinding and clicking of the humerus and positive impingement test. Range of motion was documented as flexion at 160 degrees, extension at 35 degrees, abduction at 150 degrees, internal rotation at 65 degrees and external rotation at 70 degrees. The lumbar spine was noted to be tight with spasm in the paraspinal musculature bilaterally with hypoesthesia along the anterior lateral aspect of the foot and ankle, L5 and S1 dermatomes, bilaterally. There was weakness with the big toe dorsi flexion and plantar flexion bilaterally. Range of motion was decreased with flexion at 20 degrees,

extension at 10 degrees, lateral right bending at 10 degrees and left lateral bending at 20 degrees. Straight leg raise was equal bilaterally at 145 degrees. Right knee reflexes were noted as 2 minus on the right and 2 plus on the left and Achilles were 1 plus bilaterally. There was increased pain with palpation at T4-T11 with muscles spasm. Recent thoracic spine magnetic resonance imaging (MRI) dated 07-31-2015 was documented as normal according to the interpretation by the physician's progress report on 08-14-2015. Prior treatments have included bilateral Synvisc injections on 07-10-2015, cervical epidural steroid injection, steroid injections to the right shoulder and bilateral elbows, chiropractic therapy, physical therapy and medications. Current medications were listed as Tylenol #3, Lunesta, Voltaren gel, Biofreeze and Prilosec. The injured worker remains off work on temporary total disability (TTD). Treatment plan consists of bilateral elbow braces, massage therapy, cervical epidural steroid injection and the current request on 08-14-2015 for Tylenol #3 tablets #120 with 1 refill, Prilosec 20mg #60 with 1 refill, Lunesta 3mg #30 with 1 refill, Voltaren gel 1% with 1 refill, Biofreeze gel 1% with 1 refill, 12 acupuncture therapy visits, right elbow ultrasound guided cortisone injection, right and left knee braces.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol #3 tablets #120 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The IW has been on long term opioids which are not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and appropriate.

Prilosec 20mg (#60 with 1 refill): Upheld

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

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

Decision rationale: According to MTUS guidelines it is necessary to determine if the patient is at risk for gastrointestinal events. Risk factors are: (1) age > 65 years; (2) history of peptic

ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. There was no notation of GI bleeding or perforation and no documentation of an ulcer and the IW is no longer on NSAID's. This request is not medically necessary or appropriate.

Lunesta 3mg #30 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. This request is not medically necessary and appropriate

Voltaren gel 1% (1 with 1 refill): Upheld

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

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

Decision rationale: Topical NSAID's, like diclofenac, are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. According to the documentation the IW does not have osteoarthritis of the small joints nor does the request indicate where the gel is to be utilized. This request is not medically necessary and appropriate.

Biofreeze gel 1% with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: Per ODG topical analgesics are recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. There is little to no research to support the use of many these agents. Biofreeze has active ingredients of menthol and camphor, neither of these agents have been tested nor are approved for use. Additionally, there is no documentation of prior response to this agent. The request is not medically necessary and appropriate.

12 acupuncture sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Acupuncture-Elbow, knee, neck, low back.

Decision rationale: Per acupuncture and ODG guidelines an initial trial of 3-4 visits over 2 weeks is recommended for most sites. With evidence of objective functional improvement of VAS score, treatment can be approved up to a total of 8-12 visits over 4-6 weeks. The request exceeds the guidelines. The request is not medically necessary and appropriate.

Right elbow ultrasound guided cortisone injection: Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007.

MAXIMUS guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Lateral Epicondylalgia. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow-Injections.

Decision rationale: Per ODG guidelines, steroid injections are not recommended as a routine intervention for epicondylitis, based on recent research. In the past a single injection was suggested as a possibility for short-term pain relief in cases of severe pain from epicondylitis, but beneficial effects persist only for a short time, and the long-term outcome could be poor. The significant short-term benefits of corticosteroid injection are paradoxically reversed after six weeks, with high recurrence rates, implying that this treatment should be used with caution in the management of tennis elbow. While there is some benefit in short-term relief of pain, patients requiring multiple corticosteroid injections to alleviate pain have a guarded prognosis for continued non-operative management. Corticosteroid injection does not provide any long-term clinically significant improvement in the outcome of epicondylitis, and rehabilitation should be the first line of treatment in acute cases, but injections combined with work modification may have benefit. The guidelines are for injection alone with no ultrasound guidance. There is no notation of rehab efforts or modifications to activities in the documentation. The request is not medically necessary and appropriate.

Right knee brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Activity Alteration.

Decision rationale: Per ACOEM guidelines a brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability although its benefits may be more emotional (i.e., increasing the patient's confidence) than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program. The documentation does not indicate that the IW had the conditions indicated for a brace nor that he was in a rehabilitation program. The request is not medically necessary and appropriate.

Left knee brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Activity Alteration.

Decision rationale: Per ACOEM guidelines a brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability although its benefits may be more emotional (i.e., increasing the patient's confidence) than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program. The documentation does not indicate that the IW had the conditions indicated for a brace nor that he was in a rehabilitation program. The request is not medically necessary and appropriate.