

Case Number:	CM15-0028303		
Date Assigned:	02/20/2015	Date of Injury:	05/25/2012
Decision Date:	04/08/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	02/16/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 48 year old male, who sustained an industrial injury on 05/25/2012. He has reported subsequent neck and back pain and was diagnosed with lumbar spine and cervical sprain/strain and bilateral lower extremity radiculitis. Treatment to date has included oral pain medication, a home exercise program, TENS unit, bracing, application of heat and cold, acupuncture treatment, physical therapy and chiropractic treatment. In a progress note dated 01/06/2015, the injured worker complained of 8/10 lumbar spine and bilateral lower extremity pain. Objective physical examination findings were notable for increased tenderness of the lumbar and cervical paravertebral muscles with decreased range of motion of the cervical spine and positive straight leg raise. Portions of the visit note are difficult to read so the remainder of the physical examination findings are unclear. On 01/15/2015, Utilization Review non-certified requests for 6 chiropractic visits, 1 interferential stimulator, 1 large Thermaphore cold therapy and 1 Quickdraw lumbar spine support, noting that the documentation did not support medical necessity and modified requests for Norco and Neurontin, noting that documentation did not support the efficacy of the medications. MTUS guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96 (78, 95).

Decision rationale: Per the MTUS, Ongoing management of opioid use should occur under very specific guidelines and include documentation of the 4 A's which are analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Opioids should be continued if the patient has returned to work and if there is improved functioning and pain. A review of the injured workers medical records reveal that he is reporting no change in his pain despite chronic use of opioids and is needing additional pain medication, this may represent hyperalgesia which per the MTUS is developing an unexpected change in response to opioids, development of abnormal pain, change in pain pattern or persistence of pain at higher levels than expected. Opioids in this case actually increase rather than decrease sensitivity to noxious stimuli and it is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose, but may actually require weaning. The injured worker does not appear to be having a satisfactory response to opioids therefore based on the injured workers clinical presentation and the guidelines the request for Norco 10/325mg #60 is not medically necessary.

Neurontin 600mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anticonvulsants, Antiepilepsy drugs (AEDs) Page(s): 16-22.

Decision rationale: Per the MTUS, antiepilepsy drugs like gabapentin are recommended for neuropathic pain. A good response to the use of AED's has been defined as a 50% reduction in pain and a moderate response as a 30% reduction. If there is a lack of response of at least 30% then a switch to a different first line agent like a TCA, SNRI, different AED or combination therapy if treatment with a single agent fails is recommended. 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 AED's depends on improved outcomes versus tolerability of adverse effects. A review of the injured workers medical records that are available to me and are legible do not show documentation of pain relief, improvement in function as well as side effects as recommended in the guidelines and without this information it is difficult to assess the need for continued use of gabapentin. Therefore based on the guideline recommendations the request for Neurontin 600mg #60 is not medically necessary.

Chiropractic care x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

Decision rationale: Per the MTUS, Chiropractic care/ manual therapy and manipulation are recommended for chronic pain if caused by musculoskeletal conditions, the intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patients therapeutic exercise program and return to productive activities. Per the MTUS, for the low back therapeutic care a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, for recurrences or flare up, need to re-evaluate treatment success, if RTW is achieved then 1-2 visits every 4-6 months. Time to produce effect 4-6 treatments. A review of the injured workers medical records show that he has already had up to 26 prior chiropractic treatments with no documentation of measurable gains in functional improvement. The guidelines only support 1-2 visits every 4-6 months for recurrences or flare ups and therefore based on the injured workers clinical presentation and the guidelines the request for Chiropractic care x 6 is not medically necessary.

Interferential stimulator unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: Per the MTUS, Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments. If interferential treatment is to be used, it should follow very specific guidelines as described in the MTUS in cases where pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, history of substance abuse, significant pain for post operative conditions limiting the ability to perform exercise programs/physical therapy treatments or unresponsive to conservative methods. If the criteria are met then a one month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A review of the injured workers medical records that are available to me do not show that he meets the above referenced criteria and therefore the request for Interferential stimulator unit is not medically necessary.

Large Thermaphore cold therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

Decision rationale: Per ACOEM in the MTUS, physical therapeutic interventions recommended include at-home local applications of cold in first few days of acute complaint, thereafter applications of heat or cold. This does not require the use of any special equipment and therefore the request for large thermaphore cold therapy is not medically necessary.

Quickdraw lumbar spine support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: Per ACOEM in the MTUS, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. A review of the injured workers medical records show that he has had symptoms since 5/25/2012 and he is no longer in the acute phase, therefore based on the injured workers current clinical presentation and the guidelines the request for quickdraw lumbar spine support is not medically necessary.