

Case Number:	CM15-0219030		
Date Assigned:	11/12/2015	Date of Injury:	08/31/2004
Decision Date:	12/28/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	11/06/2015

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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 is a 54-year-old female with a date of industrial injury 8-31-2004. The medical records indicated the injured worker (IW) was treated for cervical and lumbar disc disease. In the progress notes (9-23-15), the IW reported constant burning pain in the neck with intermittent sharp pain and weakness in the left arm and hand. She also reported pain and spasms in the low back with radiation to the right leg involving the calf and sometimes the toes. She complained of pain down the right leg with bowel movements. She rated her pain 8 out of 10 with Celebrex, last taken the day before her appointment. Pain relief was up to 35% if she was non-weight bearing, as the pain was aggravated by any weight bearing on the right. Pain was 6 out of 10 at its best and 10+ at its worst. Changing positions and self-massage was helpful for the pain. On examination (9-23-15 notes), there was slight swelling without erythema at the cervical paraspinals; moderate spasm and tenderness to palpation was noted here and in the greater occiput, greater on the left. Deep tendon reflexes were 2+ at the triceps and biceps on the right and 3+ on the left. Resisted upper extremity strength was within normal limits. Sensation was decreased in the C6-7 distribution. Range of motion and resisted strength was normal in the upper extremities. There was shooting pain with deep palpation of the mid-forearm on the left, raising the possibility of radial nerve entrapment. There was mild to moderate paravertebral spasm and tenderness to palpation of the lumbar spine, the sacral borders, sacroiliac joints and sciatic notches. Resisted lower extremity strength was 5 out of 5 bilaterally. Reflexes were 2+ bilaterally at the patella and Achilles, slightly stronger on the right. Seated straight leg raise was

positive on the right at 70 degrees and negative on the left at 90 degrees. Pulses and sensation were intact distally in the bilateral lower extremities. Treatments included acupuncture, which was helpful (no specifics given), physical therapy, which was minimally helpful and medications (gabapentin, acetaminophen, Celebrex (since at least 8-2015) and Amitriptyline). The IW was 'permanent and stationary' and unable to do her previous job. The treatment plan called for continuing current medications, cognitive behavioral therapy and acupuncture. A Request for Authorization dated 9-23-15 was received for Celebrex 200mg, #30 with 2 refills; outpatient cognitive behavioral therapy, six sessions; and outpatient acupuncture for the cervical and lumbar spine, six sessions. The Utilization Review on 10-9-15 non-certified the request for Celebrex 200mg, #30 with 2 refills; modified the request for outpatient cognitive behavioral therapy, six sessions; and non-certified the request for outpatient acupuncture for the cervical and lumbar spine, six sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200mg qty: 30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), Anti-inflammatory medications. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Anti-inflammatory medications are the traditional first line treatment for pain, but COX-2 inhibitors (Celebrex) should be considered if the patient has risk of GI complications, according to MTUS. The medical documentation provided does not indicate a reason for the patient to be considered high risk for GI complications. Risk factors for GI bleeding according to ODG include: (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 or multiple NSAID (e.g., NSAID + low-dose ASA). The treating physician's note dated 6/16/2013 states "The Celebrex should be discontinued because it is very effective for musculoskeletal problems but causes gastrointestinal side effects." Additionally, the medical records do not indicate that he is undergoing treatment for any of the FDA approved uses such as osteoarthritis, rheumatoid arthritis, juvenile rheumatoid arthritis in patients 2 years and older, ankylosing spondylitis, acute pain, and primary dysmenorrhea. Additionally, medically documentation provided do not indicate this patient had objective functional improvement with the use of this medication. As such, the request for Celebrex 200mg qty: 30 with 2 refills is not medically necessary.

Outpatient cognitive behavioral therapy for six (6) sessions: Upheld

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

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

Decision rationale: MTUS Pain guidelines and ODG refer to cognitive behavioral psychotherapy as "Recommended for appropriately identified patients during treatment for chronic pain." MTUS details that "Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work." ODG further states that "Initial therapy for these 'at risk' patients should be physical therapy for exercise instruction, using a cognitive motivational approach to PT. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone: - Initial trial of 3-4 psychotherapy visits over 2 weeks - With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions)." Guidelines recommend an initial trial of CBT is for 3-4 sessions, additional sessions would be approved based on progress with the initial trial. This request is in excess of guideline recommendations. As such, the request for Outpatient cognitive behavioral therapy for six (6) sessions is not medically necessary.

Outpatient acupuncture to the cervical and lumbar spine for six (6) sessions: Overturned

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) Low Back - Lumbar & Thoracic (Acute & Chronic), Neck and Upper Back, Acupuncture.

Decision rationale: MTUS "Acupuncture Medical Treatment Guidelines" clearly state that "acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery." ODG states "Under study for upper back, but not recommended for neck pain. Despite substantial increases in its popularity and use, the efficacy of acupuncture for chronic mechanical neck pain still remains unproven. Acupuncture reduces neck pain and produces a statistically, but not clinically, significant effect compared with placebo. The beneficial effects of acupuncture for pain may be due to both nonspecific and specific effects. (White, 2004) Acupuncture is superior to conventional massage, dry needling of local myofascial trigger points, and sham laser acupuncture, for improving active range of motion and pain in patients with chronic neck pain, especially in patients with myofascial pain syndrome. (Blossfeldt, 2004) (Konig, 2003) (Irnich, 2002) (Irnich, 2001) There is limited or conflicting evidence from clinical trials that acupuncture is superior to sham or active controls for relief of neck pain. There is moderate evidence that acupuncture is more effective than wait-list control for neck disorders with radicular symptoms. (Trinh, 2007) A recent study concluded that adequate acupuncture treatment may reduce chronic pain in the neck and shoulders and related headache, and the effect lasted for 3 years. (He, 2004) There is little information available from trials to support the use of many physical medicine modalities for mechanical neck pain, often employed based on anecdotal or case reports alone. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. (Kjellman, 1999) (Gross-Cochrane, 2002) (Aker, 1996) (Bigos, 1999) (Gross-Cochrane, 2004) (Birch, 2004) Another recent trial found that acupuncture is more effective than TENS placebo treatment. (Vas, 2006) This passive intervention should be an adjunct to active rehab efforts. For an overview of acupuncture and other conditions in which this modality is recommended see the Pain Chapter. ODG Acupuncture Guidelines: Initial trial of 3-4 visits over

2 weeks; With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy)." ODG does not recommend acupuncture for acute low back pain, but "may want to consider a trial of acupuncture for acute LBP if it would facilitate participation in active rehab efforts." The initial trial should "3-4 visits over 2 weeks with evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy)." The medical records indicate this patient has had previous acupuncture therapy with improved functionality and the ability to drive 20 minutes. As such, the request Outpatient acupuncture to the cervical and lumbar spine for six (6) sessions is medically necessary.