

Case Number:	CM15-0037857		
Date Assigned:	03/06/2015	Date of Injury:	08/24/2001
Decision Date:	04/21/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	02/27/2015

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: Anesthesiology

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 71 year old male, who sustained an industrial injury on 8/24/2001. The details of the initial injury were not submitted for this review. The diagnoses have included low back pain, lumbar degenerative joint disease, cervical sprain with spondylosis, thoracic sprain, trigger release fourth digit right hand, carpal tunnel release bilaterally, and constipation from narcotic use. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), analgesic, and physical therapy. Currently, the IW complains of worsening neck and back pain rated 10/10 without medication and 4-8/10 with medication. The physical examination from 2/4/15 documented limited Range of Motion (ROM) in neck and back. There were positive Phalen's and Tinel's signs bilaterally. The plan of care included continuation of home exercises, obtaining authorization for a trial of H-Wave therapy unit, and continued medication therapy. On 2/27/2015, the injured worker submitted an application for IMR for review of Glucosamine Sulfate 500mg #120, Colace 100mg #60, additional twelve (12) sessions of physical therapy, lumbar corset brace, and a thirty-day trial of H-Wave unit for home use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Glucosamine Sulfate 500mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine sulfate Page(s): 50.

Decision rationale: The California MTUS (2009) guidelines state that Glucosamine sulfate (GS) is recommended as an option, given its low risk, in patients with moderate arthritic pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline glucosamine sulfate (GS) in all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride. In this case, there is no documentation of osteoarthritis. There is documentation of neck pain, however, there is no specific indication for GS therapy. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

Colace 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Side effects of opioid analgesics.

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

Decision rationale: According to the ODG, opioid-induced constipation is a common adverse effect of long-term opioid use because of the binding of opioids to peripheral opioid receptors in the gastrointestinal tract, resulting in absorption of electrolytes and reduction in small intestine fluid. If opioids are determined to be appropriate for the treatment of pain, then prophylactic treatment of constipation should be initiated. Colace is a stool softener and is used to relieve occasional constipation. In this case, there is no documentation of opioid use. The medical necessity of Colace has not been established. The requested medication is not medically necessary.

Additional Physical Therapy x 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals

for additional treatment. In this case the patient was certified for 10 physical therapy sessions due to a flare-up of his condition. There is no documentation of functional improvement from the previously certified sessions. There is no specific indication for additional physical therapy sessions. The total number of physical therapy sessions has exceeded guideline recommendations. Medical necessity for the additional 12 PT visits requested, has not been established. The requested services are not medically necessary.

Lumbar Corset: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: According to ODG, lumbar supports are recommended as an option for compression fractures, specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP. According to the CA MTUS/ACOEM guidelines, lumbar support braces have not been shown to have a lasting benefit beyond the acute phase of symptom relief. In this case, the patient has had chronic low back pain, and does not meet the guideline criteria for a lumbar support. Medical necessity for the requested lumbar corset has not been established. The requested item is not medically necessary.

H-wave Unit 90 day trial: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT).

Decision rationale: According to the CA MTUS Guidelines (2009), H-wave stimulation (HWT) is not recommended as an isolated intervention. A one-month home-based trial of HWT may be considered as a noninvasive conservative option for diabetic neuropathic pain, or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). H-wave is used more often for muscle spasm and acute pain as opposed to neuropathy or radicular pain. In this case, there is no documentation of neuropathic pain, or documentation of conservative care, including previous TENS use. Medical necessity for the requested item has not been established. The requested HWT is not medically necessary.