MAXIMUS Federal Services

Case Number:	CM15-0067090		
Date Assigned:	04/22/2015	Date of Injury:	01/21/2003
Decision Date:	07/21/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	04/08/2015

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: 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 60 year old female, who sustained an industrial injury on January 21, 2003. She has reported neck pain, lower back pain, bilateral wrist pain, right shoulder pain, and knee pain. Diagnoses have included discogenic lumbar condition, discogenic cervical condition, impingement syndrome of the shoulder, bilateral carpal tunnel syndrome, internal derangement of the knee, and chronic pain. Treatment to date has included medications, heat, cold, chiropractic, transcutaneous electrical nerve stimulation unit, imaging studies, and diagnostic testing. A progress note dated February 11, 2015 indicates a chief complaint of neck pain, lower back pain, bilateral wrist pain, and right shoulder pain. The treating physician documented a plan of care that included medications, pain management follow up, urine screening, back brace, transcutaneous electrical nerve stimulation unit, and electromyogram/nerve conduction velocity of the bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Back Brace (Lumbar Back Support and Insert): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 5th Edition, 2007, Low Back, Supports.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

Decision rationale: This request for Back Brace (Lumbar Back Support and Insert) is evaluated in light of the MTUS recommendations. As per MTUS-ACOEM lumbar supports have not been shown to have any lasting benefit beyond the acute phase of low back pain. Medical Records of the injured worker indicate that she has chronic low back pain. As per submitted medical records and Guidelines cited, the back brace is not medically necessary and appropriate.

Nalfon 400mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 21, 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: This prescription for Nalfon is evaluated in light of the CA MTUS and Official Disability Guidelines (ODG) recommendations. Fenoprofen calcium (Nalfon) is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. According to the California MTUS Guidelines, NSAIDs reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), short-term pain relief and improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain. Current evidence-based guidelines indicate that Fenoprofen is an NSAID medication which is less effective, and has greater side effects than Naproxen or Ibuprofen. Guidelines indicate that Fenoprofen should not be used unless there is a sound medical basis for not using a safer or more effective alternative NSAID. In this case, there was no rationale provided which explained the request for Fenoprofen. Medical necessity of the requested medication has not been established. The requested item is not medically necessary. REF: MTUS Anti-inflammatory medications, NSAIDs, PP 21, 67-71 & ODG, NSAIDs.

Protonix 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - Proton pump inhibitors (PPIs).

Decision rationale: There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Protonix has not been established. Therefore the request is not medically necessary.

Neurontin 600mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18-20, 49, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-20,49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - Neurontin (gabapentin.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. The records documented that this injured worker has chronic pain. Neurontin has been part of her medical regimen. However, there is no documentation of subjective or objective findings consistent with improvement of pain to necessitate use of Neurontin. Medical necessity for Neurontin has not been established. Therefore the request is not medically necessary.

Norflex 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - Muscle relaxants (for pain).

Decision rationale: According to the ODG, Orphenadrine (Norflex) is a muscle relaxant similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. According to CA MTUS guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory drugs (NSAIDs) alone, and are not recommended for the long-term use of chronic pain. In this case, the patient has been prescribed NSAIDs for breakthrough pain. Based on the currently available information, the medical necessity for Orphenadrine has not been established. The requested medication is not medically necessary

Ultracet 37.5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol (Ultram) Page(s): 75, 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97.

Decision rationale: The medication requested for this patient is Ultracet (Tramadol plus Acetaminophen). According to the California MTUS, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain, with any opioid, requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. According to the medical documentation there has been no indication of the medication's pain relief effectiveness and no clear documentation that the patient has responded to ongoing opioid therapy. Per California MTUS Guidelines, there have to be certain criteria followed, including an ongoing review and documentation of pain relief and functional status. Medical necessity for the requested medication has not been established. The requested treatment with Ultracet is not medically necessary.

TENS Unit with Garment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 115-116.

Decision rationale: Per CA MTUS guidelines TENS unit is not recommended as a primary modality, but a one month home-based trial may be considered if used as an adjunct to a program of evidence-based functional restoration, with documentation of how often the unit was used. A treatment plan that includes the specific short and long term goals of treatment with TENS unit cannot be located in the submitted Medical Records. MTUS Guideline does support rental of this unit at the most for one month, but Medical Records of this injured worker are not clear about its benefits from the past use. Submitted Medical Records (dated May 22, 2013) state "She does not prefer TENS Unit." The Requested Treatment TENS Unit with Garment is not medically necessary and appropriate.

EMG/NCV of the Right Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC, EMG.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177 and 179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS/ACOEM Guidelines state, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The ODG regarding nerve conduction studies (NCS) states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The records of injured worker mention bilateral wrist pain. The objective findings on examination did not include evidence of neurologic dysfunction such as sensory, reflex, or motor system change. The injured worker is not presented as having radiculopathy and there were no symptoms or findings that define evidence of a peripheral neuropathy. There is insufficient information provided by the attending health care provider to establish the medical necessity or rationale for the requested electrodiagnostic studies. The request for an EMG/NCV of the Right Upper Extremity is not medically necessary and appropriate.

EMG/NCV of the Left Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC, EMG.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177 -179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS/ACOEM Guidelines state, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The ODG regarding nerve conduction studies (NCS) states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The records of injured worker mention bilateral wrist pain. The objective findings on examination did not include evidence of neurologic dysfunction such as sensory, reflex, or motor system change. The injured worker is not presented as having radiculopathy and there were no symptoms or findings that define evidence of a peripheral neuropathy. There is insufficient information provided by the attending health care provider to establish the medical necessity or rationale for the requested electrodiagnostic studies. The request for an EMG/NCV of the Left Upper Extremity is not medically necessary and appropriate.