

Case Number:	CM14-0139187		
Date Assigned:	09/05/2014	Date of Injury:	04/24/2014
Decision Date:	10/09/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	08/28/2014

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. The expert reviewer is Board Certified in Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 50-year-old female who reported an injury on 03/24/2014 due to an unknown mechanism. Diagnoses were lumbar radiculopathy, cervical radiculopathy, and right shoulder impingement. Past treatments were not reported. Diagnostic studies were an MRI of the lumbar spine, right shoulder, and cervical spine. The surgical history was not reported. The physical examination on 07/15/2014 revealed complaints of neck pain that radiated into the right arm and low back pain that radiated into the right leg. The pain was reported a 10/10. The examination of the cervical spine revealed pain on cervical range of motion, particularly in the right trapezial and left paracervical ridge. There was spasm across the right trapezius and left trapezius. The right shoulder examination revealed that the injured worker had a positive impingement, but there was full range of motion. The examination of the lumbar spine revealed moderate pain across the lower back. The lower back range of motion was normal, but there was evidence of spasm. The straight leg raise was positive in the right leg at 70 degrees with positive Lasegue's. It was negative on the left at 90 degrees. Sensation was normal in both lower extremities. Deep tendon reflexes were 2+ at both knees and ankles. Medications were Naprosyn, Prilosec, and Ultram extended release. The treatment plan was for a TENS unit, lumbar support, and chiropractic sessions. The rationale was not submitted. The Request for Authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 TENS Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Chronic Pain (Transcutaneous Electrical Nerve Stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, NMES, Interferential Current Stimulation Page(s): 114-116, 121, 118.

Decision rationale: The decision for 1 TENS unit is not medically necessary. The California Medical Treatment Utilization Schedule recommends a 1 month trial of TENS unit as an adjunct to a program of evidence based functional restoration for chronic neuropathic pain. Prior to the trial, there must be documentation of at least 3 months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. They do not recommend neuromuscular electrical stimulation (NMES) devices as there is no evidence to support its use in chronic pain. They do not recommend interferential current stimulation (ICS) as an isolated intervention. The medical guidelines state that before use of a TENS unit, there should be documentation or evidence that other appropriate pain modalities have been tried, such as physical therapy, acupuncture, or chiropractic sessions. Therefore, this request is not medically necessary.

1 Prescription of Prilosec: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Tramadol (Ultram)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, Page(s): 67.

Decision rationale: The decision for 1 Prescription of Prilosec is not medically necessary. Clinicians should determine if the patient is at risk for gastrointestinal events which include age > 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. Patients at high risk for gastrointestinal events with no cardiovascular disease should be recommended a Cox-2 selective agent plus a PPI if absolutely necessary. The injured worker did not have any complaints of gastrointestinal events. The efficacy of this medication was not reported also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

1 Prescription of Ultram: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Ongoing Management, Page(s): 82, 93, 94,113,78.

Decision rationale: The decision for 1 prescription of Ultram is not medically necessary. The California Medical Treatment Utilization Schedule states central analgesic drugs such as tramadol (Ultram) are reported to be effective in managing neuropathic pain and it is not recommended as a first line oral analgesic. The medical guidelines recommend that there should be documentation of the "4 A's" for ongoing monitoring (including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The 4 "A's" for ongoing monitoring were not reported. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Retrospective request for an Injection of Celestone and 2 cc of Marcaine to the left lumbar spine, DOS 7/15/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back- Lumbar & Thoracic (Acute & Chronic)

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

Decision rationale: The decision for retrospective request for an injection of Celestone and 2 cc of Marcaine to the left lumbar spine, DOS 07/15/2014 is not medically necessary. The ACOEM Guidelines state invasive techniques (e.g., local injections and facet joint injections of cortisone or lidocaine) are of questionable merit. Although epidural steroid injections may afford short term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. There were no significant factors reported to justify the injection of Celestone and 2 cc of Marcaine to the left lumbar spine. The medical guidelines do not support the use of invasive techniques such as local injections and facet joint injections. Therefore, the request is not medically necessary.

18 chiropractic therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation, Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58-59.

Decision rationale: The decision for 18 chiropractic therapy sessions is not medically necessary. The California Medical Treatment Utilization Schedule states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions, and with objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. Treatment for flare ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle and foot, carpal tunnel syndrome, the forearm, wrist, hand, or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks, and at 8 weeks, patients should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful and improving function, decreasing pain, and improving quality of life. The request submitted for 18 therapy sessions exceeds the recommended 6 sessions with objective functional improvement. Therefore, the request is not medically necessary.

Lumbar support, quantity 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back- Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The decision for lumbar support, quantity 1, is not medically necessary. The ACOEM Guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, continued use of back braces could lead to deconditioning of the spinal muscles. The medical guidelines do not support the use of lumbar supports. Therefore, the request is not medically necessary.