

Case Number:	CM14-0142948		
Date Assigned:	09/10/2014	Date of Injury:	10/08/2006
Decision Date:	10/10/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/03/2014

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 Occupational Medicine, and is licensed to practice in California. 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:

Patient is a 63-year-old male who has submitted a claim for cervicalgia, chronic pain syndrome, cervical spondylosis with myelopathy, anterior spinal artery compression syndrome, thoracic spondylosis with myelopathy, thoracic arthritis, osteoarthritis, lumbosacral spondylosis without myelopathy, carpal tunnel syndrome, and shoulder pain associated with an industrial injury date of 10/8/2006. Medical records from 2014 were reviewed. Patient complained of persistent back pain, rated 5/10 in severity, and relieved to 4/10 upon intake of medications. Patient likewise complained of shoulder pain, subscapular pain, and right arm pain described as constant, dull, throbbing, and achy. Neck pain radiated to bilateral upper extremities. Physical examination of the lumbar spine showed tenderness and muscle spasm. Examination of the cervical spine showed decreased motion and negative Spurling's maneuver. Range of motion of both shoulders was restricted towards abduction. Treatment to date has included lumbar surgery, acupuncture (with noted improvement), physical therapy, and medications such as Ambien (since July 2014), Trazodone, Tramadol (since March 2014), Norco, Lidoderm patch (since July 2014), Colace, Naprosyn (since March 2014), Lexapro, and topical creams. The request for chiropractic care was intended for cervical/thoracic spine. Progress report from 7/9/2014 stated that patient reported no improvement in sleep from Ambien use. Utilization review from 8/26/2014 denied the request for additional acupuncture x 9 because of no documentation of improved objective findings from previous sessions; modified the request for chiropractic care (unspecified) into two x 3 as trial visits due to persistence of back and neck symptoms; denied Lidoderm 5% patch, #14 x 5 refills because there was no evidence of any localized neuropathic pain; modified the request for Naprosyn 500mg (Unspecified) x 2 Refills into Naprosyn 500 mg, #60 without refill because of no discussion concerning need for multiple refills; denied Ambien 5 mg because there was no

current documentation of insomnia; and denied Tramadol 50 mg, #30 x 1 refills because there was no documentation of improved functional status with medication use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Acupuncture x 9: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: CA MTUS Acupuncture Medical Treatment Guidelines 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. Acupuncture treatments may be extended if functional improvement is documented. The frequency and duration to produce functional improvement is 3 - 6 treatments, frequency of 1 - 3 times per week, and duration of 1 - 2 months. It may be extended if functional improvement is documented. In this case, patient has received acupuncture treatment in the past; however, the exact number of visits is not documented in the medical records submitted. Patient noted improvement from acupuncture; however, there was no documentation stating the pain reduction, functional improvement or decreased medication-usage associated with it. Moreover, body part to be treated is not specified. Therefore, the request for additional acupuncture x 9 is not medically necessary.

Chiropractic care (unspecified): Upheld

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

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

Decision rationale: As stated on pages 58-59 of CA MTUS Chronic Pain Medical Treatment Guidelines, several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. There should be some outward sign of subjective or objective improvement within the first 6 visits for continuing treatment. In this case, chiropractic care is requested due to persistent neck pain and back pain despite physical therapy, acupuncture, and intake of medications. Manipulation therapy is a reasonable treatment option. However, the request failed to specify body part to be treated and intended number of sessions. Therefore, the request for chiropractic care (unspecified) is not medically necessary.

Lidoderm 5% patch #14 x 5 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine patch Page(s): 56-57.

Decision rationale: Pages 56 to 57 of CA MTUS Chronic Pain Medical Treatment Guidelines state that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). In this case, records reviewed showed that the patient was on Lidoderm patch since July 2014 due to persistent neuropathic pain symptoms despite Lexapro prescription. However, there is no documentation concerning significant pain relief and functional improvement derived from its use. The medical necessity cannot be established due to insufficient information. Therefore, the request for Lidoderm 5% patch, #14 x 5 refills is not medically necessary.

Naprosyn 500mg (unspecified) x 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 46.

Decision rationale: As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, patient has been on Naprosyn since March 2014. However, there is no documentation concerning significant pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. Therefore, the request for Naprosyn 500 mg (unspecified) x 2 refills is not medically necessary.

Ambien 5mg (unspecified): 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), Chronic Pain, Non-Benzodiazepine Hypnotic

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

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Pain Section was used

instead. The Official Disability Guidelines state that Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for short-term usually 2-6 weeks treatment of insomnia. In this case, patient has been on Ambien since July 2014 for sleep disturbance. However, there is no discussion concerning improvement with medication use. Furthermore, there is no recent discussion concerning sleep hygiene. The request likewise failed to specify dosage and quantity to be dispensed. Therefore, the request for Ambien 5 mg (unspecified) is not medically necessary.

Tramadol HCL 50mg #30 x 1 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on tramadol since March 2014. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for tramadol HCL 50mg, #30 x 1 refill is not medically necessary.