

Case Number:	CM14-0028628		
Date Assigned:	06/20/2014	Date of Injury:	03/29/2004
Decision Date:	08/18/2014	UR Denial Date:	01/30/2014
Priority:	Standard	Application Received:	03/06/2014

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 Physical Medicine & Rehabilitation has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 63-year-old female who reported an injury related to a motor vehicle accident on 03/29/2004. On 04/29/2014, her diagnoses included degeneration of cervical intervertebral disc, cervical disc displacement, cervical radiculitis and anxiety disorder. It was noted in the report of 03/05/2013 that this worker had undergone electromyography and nerve conduction studies on an unknown date with documentation of neuropathy and postsurgical changes, but no body part was mentioned. It is further noted that she had completed x-rays and MRIs. Once again there were no objective interpretations or results attached to the documentation. The report further states that she had tried ice, NSAIDs, rest, heat application and physical therapy. No quantifiable results were attached to the documentation. On 10/29/2013, it was noted that she had undergone an unknown number of acupuncture treatments between 09/03/2013 and 10/29/2013. The reports stated that her symptoms improved 50% and that the acupuncture treatments allowed her to tolerate the pain and perform her daily activities. Per the report of the acupuncturist, her pain was reduced from 8/10 to 4/10 after the acupuncture treatments for neck and shoulder pain. In the report from 02/20/2013, this worker reported pain in the neck and right shoulder, headache and paresthesia in her right hand. Additionally, there was numbness and weakness in the right groin. She also had gastrointestinal and gastro esophageal reflux disease (GERD) symptoms. The physical examination of 04/29/2014 revealed an asymmetry of the neck and shoulders with a tilting of the head and neck to the left. On axial compression of the cervical spine, there was right trapezius tenderness. The cervical spine range of motion measured in degrees, were, forward flexion 45, backward extension 45, right and left lateral tilt 30, right and left rotation 60. Her medications included Norco 325/5 mg, lorazepam 1 mg, Zofran 4 mg, Prilosec 20 mg, Lyrica 75 mg, Voltaren gel 1% and Flector patch 1.3%. There

was no rationale included with the documentation. Requests for Authorization dated 01/30/14 were found for the internal medicine referral, gastroenterologist referral and the acupuncture. There were no requests for authorization for the otolaryngologist, Lorazepam, Zofran, Prilosec or Lidoderm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture three (3) times a week for three (3) weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture 3 times a week for 3 weeks is non-certified. The California MTUS Guidelines recommend that acupuncture is an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical therapy and/or surgical intervention to aid in functional recovery. The recommended frequency of treatment is 1 to 3 times per week with functional improvement noted in 3 to 6 treatments. The optimum duration of treatments is 1 to 3 months. It further states that acupuncture treatments may be extended if functional improvement is documented. There is no documentation in this worker's chart, that her pain medications were reduced with her previous acupuncture treatments, or that she was not tolerating them. There was no documentation of quantifiable functional improvement or length of time that any pain relief lasted with her prior acupuncture treatments. Therefore, the request for acupuncture 3 times a week for 3 weeks is non-certified.

Referral for Internal Medicine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89.

Decision rationale: The request for referral for internal medicine is non-certified. Per ACOEM Disability Prevention Management Guidelines, under the optimal system, a clinician acts as the primary case manager. The clinician provides appropriate medical evaluation and treatment and adheres to conservative evidence based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously select and refer to specialist who will support functional recovery as well as provide expert medical recommendations. The submitted documentation does not include specific objective justifications for an internal medicine consultation. Therefore, this request for referral for internal medicine is non-certified.

Referral to Gastroenterologist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89.

Decision rationale: The request for referral to gastroenterologist is non-certified. Per ACOEM Disability Prevention Management Guidelines, under the optimal system, a clinician acts as the primary case manager. The clinician provides appropriate medical evaluation and treatment and adheres to conservative evidence based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously select and refer to specialist who will support functional recovery as well as provide expert medical recommendations. The submitted documentation does not include specific objective justifications for a gastroenterologist consultation. Therefore, this request for referral to gastroenterologist is non-certified.

Referral to Otolaryngologist (ENT): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89.

Decision rationale: The request for referral to Otolaryngologist (ENT) is non-certified. Per ACOEM Disability Prevention Management Guidelines, under the optimal system, a clinician acts as the primary case manager. The clinician provides appropriate medical evaluation and treatment and adheres to conservative evidence based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously select and refer to specialist who will support functional recovery as well as provide expert medical recommendations. The submitted documentation does not include specific objective justifications for an otolaryngologist consultation. Therefore, this request for referral for an otolaryngologist is non-certified.

Prescription of Lorazepam 1mg, one (1) twice a day (bid), #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazapine Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The request for prescription of lorazepam 1 mg 1 twice a day #60 is non-certified. The California MTUS Guidelines do not recommend benzodiazepines for long term use because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit the use to 4 weeks. The range of action includes sedative, hypnotic, anxiolytic, anticonvulsant and muscle relaxant effects. Chronic benzodiazepines are the treatment choice of very few clinicians. Tolerance to hypnotic effect develops rapidly. Tolerance to anxiolytic effects occurs within months and long term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsants and muscle relaxants effects occurs within weeks. The action of lorazepam is that of an anxiolytic and this worker does not have a diagnosis of anxiety disorder. Additionally she has been using this medication longer than the guidelines suggest. Therefore, this request for a prescription of lorazepam 1 mg 1 twice a day, #60 is non-certified.

Prescription of Zofran 4mg, one (1) every day, #30: 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), Pain Chapter, Ondansetron (Zofran).

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

Decision rationale: The request for a prescription for Zofran 4 mg 1 everyday #30 is non-certified. Per ODG guidelines, Zofran is a serotonin 5-HT₃ receptor antagonist. It is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for postoperative use. Acute use is FDA approved for gastroenteritis. As with other anti-emetics, routine prophylaxis is not recommended for injured workers in whom there is little expectation that the nausea and/or vomiting will occur postoperatively. There was no documentation submitted that this worker was being treated with cancer chemotherapy, full-body or single dose irradiation or that she was a candidate for surgery with a high expectation of postoperative nausea and vomiting. Therefore, this request for prescription of Zofran 4 mg, 1 everyday, #30 is non-certified.

Prescription of Prilosec 20mg, one (1), every day, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk. Decision based on Non-MTUS Citation http://www.accessdata.fda.gov/drugsatfda_docs/label/2006/019810s0831bl.pdf.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The request for a prescription of Prilosec 20 mg, 1 everyday #30 is non-certified. The California MTUS Guidelines suggest that it must be determined that the patient is at risk for gastrointestinal events. Contributing factors may include age greater than 65 years,

history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of ASA, corticosteroids and/or an anticoagulant or high dose or multiple NSAIDS. Prilosec, which is a proton pump inhibitor is recommended if the patient is at intermediate risk for gastrointestinal events and has no cardiovascular disease. There is no documentation submitted that this worker is at intermediate risk for gastrointestinal events. Therefore, the request for a prescription of Prilosec 20 mg, 1 everyday #30 is non-certified.

Prescription of Lidoderm film 5%, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The request for a prescription of Lidoderm film 5%, #30 is non-certified. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized control trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to the affected areas with advantages that include lack of systemic side effects, absence of drug interactions and no need to titrate. Many agents are compounded as monotherapy for pain control including local anesthetics. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Lidocaine is recommended for localized peripheral pain after there has been evidence of trials of first line therapy including antidepressants and antiepileptic medications. The only form of FDA approved topical application of lidocaine, is a dermal patch for neuropathic pain. There is no documentation submitted that this worker has failed previous trials of first line therapy including antidepressants or antiepileptic medications. Additionally, there is no body part specified to which this requested Lidoderm film was to have been applied, or frequency of application. Therefore, this request for prescription for Lidoderm film 5%. #30 is non-certified.