

Case Number:	CM15-0110841		
Date Assigned:	06/19/2015	Date of Injury:	10/15/2008
Decision Date:	09/22/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	06/09/2015

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: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 76 year old male who sustained an industrial injury on 10/15/08. Initial complaints and diagnoses are not available. Treatments to date include medications. Diagnostic studies are not addressed. Current complaints include low back and right knee pain. Current diagnoses include lumbar strain, and history of right foot /ankle/knee contusion. In a progress note dated 04/22/15 the treating provider reports the plan of care as medications including Tramadol, Prilosec, Flexeril, transportation, deep tissue massage, and a TENS unit trial, as well as continued home exercise program and a gym membership. The requested treatments include Prilosec, deep tissue massage, Flexeril, a TENS unit trial, and transportation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg #60: 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 Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: This patient presents with chronic lower back and right knee pain. The current request is for Prilosec 20mg #60. The RFA is dated 04/22/15. Treatment to date has included medications. Other previous treatments are not discussed. The patient is not working. MTUS Chronic Pain Guidelines page 69 regarding NSAIDs, GI symptoms & cardiovascular risk states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." According to progress report 04/122/15, the patient presents with low back and right knee pain. Examination revealed antalgic gait, positive SLR on the right, tenderness in the thoracic and lumbar paravertebral, and tenderness in the medial joint line of the bilateral knees. The treater requests a refill of Prilosec "for stomach protection. This is prescribed and dispensed to decrease the risk of gastrointestinal upset and irritation." Prophylactic use of PPI is indicated by MTUS. However, there are no NSAID's included in patient's medications. Furthermore, the treater has not provided GI risk assessment for prophylactic use of PPI, as required by MTUS. Provided progress reports do not show evidence of gastric problems, and there is no mention of GI issues. This request is not in accordance with guideline indications. Therefore, the request IS NOT medically necessary.

Deep tissue massage two times three: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

Decision rationale: This patient presents with chronic lower back and right knee pain. The current request is for Deep tissue massage two times three. The RFA is dated 04/22/15. Treatment to date has included medications. Other previous treatments are not discussed. The patient is not working. MTUS Chronic Pain Guidelines page 60 on Massage therapy states, "Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. Scientific studies show contradictory results. Furthermore, many studies lack long-term follow-up. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided." According to progress report 04/122/15, the patient presents with low back and right knee pain. Examination revealed antalgic gait, positive SLR on the right, tenderness in the thoracic and lumbar paravertebral, and tenderness in the medial joint line of the bilateral knees. The treater requests a trial course of Deep tissues massage two times per week for three weeks. MTUS supports massage therapy as an option and states that it should be "limited to 4-6 visits in most cases." There is no indication of previous massage therapy and a trial of 6 sessions at this juncture is reasonable and supported by MTUS. This request IS medically necessary.

Flexeril 7.5mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: This patient presents with chronic lower back and right knee pain. The current request is for Flexeril 7.5mg #30. The RFA is dated 04/22/15. Treatment to date has included medications. Other previous treatments are not discussed. The patient is not working. MTUS Chronic Pain Guidelines pages 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are Carisoprodol, Cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and relaxant effects. According to progress report 04/122/15, the patient presents with low back and right knee pain. Examination revealed antalgic gait, positive SLR on the right, tenderness in the thoracic and lumbar paravertebral, and tenderness in the medial joint line of the bilateral knees. The treater requests a refill of Flexeril for "muscle relaxation." It is unclear when Flexeril was initiated. MTUS recommends Flexeril for only for a short period (no more than 2-3 weeks). The current request is for #30 and the treater does not state that this medication is intended for short-term use only. This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.

E-stim for home use (trial basis) for 6-8 weeks: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter under Electrical stimulators (E-stim), Knee chapter under Electrical stimulators (E-stim).

Decision rationale: This patient presents with chronic lower back and right knee pain. The current request is for E-stim for home use (trial basis) for 6-8 weeks. The RFA is dated 04/22/15. Treatment to date has included medications. Other previous treatments are not discussed. The patient is not working. ODG Guidelines, Low back chapter under Electrical stimulators (E-stim) states: "See more specific therapy. The following are choices: Bone-growth stimulators (BGS); Hyperstimulation analgesia; H-wave stimulation (devices); Interferential therapy; Localized high-intensity neurostimulation; Microcurrent electrical stimulation (MENS

devices); Neuroreflexotherapy; Neuromuscular electrical stimulation (NMES); Percutaneous electrical nerve stimulation (PENS); Percutaneous neuromodulation therapy (PNT); Spinal cord stimulation; Sympathetic therapy; & Transcutaneous electrical neurostimulation (TENS)." ODG Guidelines, Knee chapter under Electrical stimulators (E-stim) states: "See more specific therapy. The following are choices: ARP wave therapy; BioniCare knee device; Bone-growth stimulators (BGS); Interferential current stimulation (ICS); Neuromuscular electrical stimulation (NMES); Periosteal stimulation therapy (PST); Pulsed magnetic field therapy (PMFT); Transcutaneous electrical neurostimulation (TENS). The AHRQ Comparative Effectiveness Review of PT for knee arthritis concluded that E-stim improved global assessment, but worsened pain, and did not improve disability, health perception, and gait, joint, transfer, and composite function measures." (Shamliyan, 2012) According to progress report 04/122/15, the patient presents with low back and right knee pain. Examination revealed antalgic gait, positive SLR on the right, tenderness in the thoracic and lumbar paravertebral, and tenderness in the medial joint line of the bilateral knees. The treater requests an "electrical stimulation for home care use on trial basis for six to eight weeks." In this case, the treater does not specify what time of electrical stimulation unit is being requested. In addition, there is no discussion as to which injured body part this unit is to be used on. Without knowing what specific unit is being requested, the appropriate guidelines cannot be applied and therefore, the medical necessity cannot be established. The request IS NOT medically necessary.

Transportation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter under Transportation (to & from appointments) and Other Medical Treatment Guidelines www.aetna.com: Transportation.

Decision rationale: This patient presents with chronic lower back and right knee pain. The current request is for Transportation. The RFA is dated 04/22/15. Treatment to date has included medications. Other previous treatments are not discussed. The patient is not working. ODG-TWC guidelines, Knee chapter under Transportation (to & from appointments) states: "Recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport (CMS, 2009)." www.aetna.com: Transportation-AETNA has the following guidelines on transportation: "The cost of transportation primarily for and essential to, medical care is an eligible medical expense. The request must be submitted for reimbursement and the request should document that patient cannot travel alone and requires assistance of a nurse or companion." According to progress report 04/122/15, the patient presents with low back and right knee pain. Examination revealed antalgic gait, positive SLR on the right, tenderness in the thoracic and lumbar paravertebral, and tenderness in the medial joint line of the bilateral knees. Current diagnoses include lumbar strain, and history of right foot /ankle/knee contusion. The treater requests Transportation for the patient as "he does have difficulty driving and it is very difficult for him to get a ride every time from someone." ODG and Aetna do support transportation services if it is essential to medical

care. In this case, the patient has reported that it is "difficult" to drive; however, examination and diagnoses do not show deficits that compromise the patient's ability to drive or take public transportation. There is no discussion regarding social situation either. This request IS NOT medically necessary.