

Case Number:	CM15-0124493		
Date Assigned:	07/16/2015	Date of Injury:	12/20/2005
Decision Date:	09/08/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	06/29/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 31 year old, male who sustained a work related injury on 12/20/05. He slipped on some liquid on the floor landing on his back and buttocks. The diagnoses have included lumbosacral strain with left lumbar radiculopathy, secondary gastroesophageal reflux disease (GERD) due to chronic use of medications, anxiety, depression and insomnia. Treatments have included chiropractic treatments without benefit, medications, psychotherapy, massage therapy and heat/ice therapy. In the PR-2 dated 5/22/15, the injured worker complains of low back pain with radiation to the left buttock, posterior thigh and toes with intermittent tingling. He rates his pain level a 5/10 with medications and an 8-10 without medications. He has mild paralumbar muscle spasm, left worse than right. He has decreased range of motion in his lumbar spine. He has a positive left straight leg raise. He continues to have sensation that his leg is going to give out on him. He complains of daily headaches. He complains of depression, insomnia and frustration. He complains of gastrointestinal upset due to medication usage. He is not working. The treatment plan includes requests for massage therapy, for an Orthostim unit, for an MRI of the lumbar spine and refills of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Massage therapy 2 times a week to lumbar/thoracic: Upheld

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

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

Decision rationale: Per CA MTUS guidelines, massage therapy "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. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain." "Massage is an effective adjunct treatment to relieve acute postoperative pain in patients who had major surgery, according to the results of a randomized controlled trial recently published in the Archives of Surgery." In the provider's report, the injured worker found this treatment very effective in decreasing his pain. There is insufficient documentation on how this decreased his pain and if he obtained improved functional capacity. For these reasons, the requested treatment of massage therapy is not medically necessary.

OrthoStim unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 121.

Decision rationale: Per CA MTUS guidelines, Orthostim is a type of neuromuscular electrical stimulation device. This is not recommended. It is used as part of a rehabilitation program when the person has had a stroke. There is no evidence to support its use in chronic pain issues. There are no trials suggesting any benefit from using this device for chronic pain. Since this device is not recommended for use in chronic pain issues, the requested treatment of an Orthostim unit is not medically necessary.

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: Per CA MTUS, ACOEM guidelines, "unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to

warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)." The provider requested an MRI of the lumbar for further evaluation and underlying pathology. There are no drastic changes in his symptoms that would suggest that he needs an MRI for a possible procedure. Therefore, the requested treatment of an MRI of the lumbar spine is not medically necessary.

Lunesta 3mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Insomnia.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Sedative Hypnotics.

Decision rationale: Per ODG, Lunesta is a sedative hypnotic. It is not recommended for long-term use. For short term use. "While sleeping pills are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term." He has been taking this medication for undetermined length of time without documentation of improvement in sleep latency, quality or quantity. There is insufficient documentation of other non pharmacological treatments suggested to help sleep besides taking medication. This medication is not for long-term use. Therefore, the requested treatment of Lunesta is not medically necessary.

Lexapro: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 16.

Decision rationale: Per CA MTUS guidelines, Lexapro is considered a selective serotonin reuptake inhibitor (SSRI). SSRIs are "a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials." "It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain." He has diagnoses of anxiety and depression. There is insufficient documentation on how this medication is helping to reduce his anxiety, depression or chronic pain. The requested treatment of Lexapro is not medically necessary.

Lyrica 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs, Lyrica Page(s): 16-20, 58.

Decision rationale: Per CA MTUS guidelines, "Pregabalin (Lyrica) has been documented to be effective in treatment of diabetic neuropathy and post-herpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia." "Recommended for neuropathic pain (pain due to nerve damage)." "There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at post-herpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy." The response is considered "good" if antiepilepsy drug (AEDs) yields a 50% reduction in pain. A "moderate" response is defined as a 30% reduction in pain. "AEDs are recommended on a trial basis (gabapentin/pregabalin) as a first-line therapy for painful polyneuropathy (with diabetic polyneuropathy being the most common example)." He has been taking this medication for an undetermined length of time. There is insufficient documentation how Lyrica is easing his radiculopathy symptoms, decreasing his pain or improving his functional capabilities. Since there has been no changes in pain levels or no documented changes in functional capabilities, the requested treatment of Lyrica is not medically necessary.