MAXIMUS Federal Services

Case Number:	CM15-0140780		
Date Assigned:	08/14/2015	Date of Injury:	05/09/2012
Decision Date:	10/02/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/21/2015

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 a 54-year-old female, who sustained an industrial injury on May 9, 2012, incurring upper and lower back, shoulders, upper extremities and left leg injuries from repetitive job duties. Lumbar Magnetic Resonance Imaging revealed disc disease, disc bulging, and bilateral facet disease. She was diagnosed with a torn ligament in her shoulder, neck sprain and lumbar sprain, brachial neuritis and thoracic and lumbosacral neuritis. Treatment included physical therapy, pain medications, neuropathic medications, anti-inflammatory drugs, epidural steroid injections, and activity restrictions and modifications. Currently, the injured worker complained of persistent neck and low back pain rating it 8 out of 10 on a pain scale. She noted the neck pain was constant and radiated to the shoulders and into the arms with numbness and tingling. The low back pain radiated into the lower left leg and into the toes with numbness, cramping and tingling. She noted muscle weakness and loss of strength with decreased range of motion of the upper and lower extremities. The treatment plan that was requested for authorization included a prescription for Gabapentin and a purchase for a Home Interferential Unit for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 100mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs, Anti-Convulsants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18-19.

Decision rationale: Based on the 07/30/15 progress report provided by treating physician, the patient presents with neck pain that radiates to the right upper extremity, low back pain that radiates to the bilateral lower extremities and bilateral shoulder pain, rated 7/10. The request is for GABAPENTIN 100MG #90. Patient's diagnosis per Request for Authorization form dated 07/30/15 includes cervical disc disorder, shoulder tinnitus, lumbar IVD displacement without myelopathy, brachial neuritis or radiculitis, and neuritis/radiculitis thoracic/lumbosacral. Physical examination on 07/30/15 revealed tenderness to the cervical, thoracic, lumbar lumbosacral, sacroiliac and shoulder regions. Range of motion to cervical spine and the bilateral shoulders slightly decreased. MRI of the right shoulder dated 04/19/15, per 07/30/15 report revealed 2cm tear of the supraspinatus tendon, 2cm proximal to the insertion site and greater tuberosity, with fluid in the subacromial subdeltoid bursa indicating a full thickness tear.Treatment has included imaging studies, physical therapy, acupuncture, epidural steroid injections, activity restrictions and modifications, and medications. The patient is temporarily totally disabled, per 07/30/15 report. MTUS Guidelines, Gabapentin, pages 18 and 19 revealed the following: "Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and post therapeutic neuralgia and has been considered a first-line treatment for neuropathic pain." MTUS page 60 also states, "A record of pain and function with the medication should be recorded, when medications are used for chronic pain." Per 07/30/15 report, treater states Gabapentin was prescribed "for peripheral pain (neurological pain). Based on medical records, it appears treater is initiating Gabapentin; hence treater did not have the opportunity to document efficacy of this medication. The patient continues with pain and neuropathic symptoms for which this medication is indicated. This request appears reasonable and in accordance with guidelines. Therefore, the request is medically necessary.

Home Interferential Unit for purchase for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): s 118-120.

Decision rationale: Based on the 07/30/15 progress report provided by treating physician, the patient presents with neck pain that radiates to the right upper extremity, low back pain that radiates to the bilateral lower extremities and bilateral shoulder pain, rated 7/10. The request is for HOME INTERFERENTIAL UNIT FOR PURCHASE FOR THE RIGHT SHOULDER. Patient's diagnosis per Request for Authorization form dated 07/30/15 includes cervical disc disorder, shoulder tinnitus, lumbar IVD displacement without myelopathy, brachial neuritis or radiculitis, and neuritis/radiculitis thoracic/lumbosacral. Physical examination on 07/30/15 revealed tenderness to the cervical, thoracic, lumbar lumbosacral, sacroiliac and shoulder regions. Range of motion to cervical spine and the bilateral shoulders slightly decreased. MRI of the right shoulder dated 04/19/15, per 07/30/15 report revealed 2cm tear of the supraspinatus tendon, 2cm proximal to the insertion site and greater tuberosity, with fluid in the subacromial subdeltoid bursa indicating a full thickness tear. Treatment has included imaging studies,

physical therapy, acupuncture, epidural steroid injections, activity restrictions and modifications, and medications. The patient is temporarily totally disabled, per 07/30/15 report. MTUS pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "While not recommended as an isolated intervention, patient selection criteria if Interferential stimulation is to be used anyway; possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." Per 07/30/15 report, treater states "I prescribe the IF unit for home use and pain relief purposes. The interferential unit is used as a multimodality approach to pain control and functional restoration." Medical records show the requested treatment is not intended as an isolated intervention, since treater is requesting acupuncture concurrently. With regards to interferential unit, there is no evidence that pain is not effectively controlled due to the effectiveness of medication, substance abuse or pain due to postoperative conditions or unresponsiveness to conservative measures. Treater is requesting purchase of IF unit for home use. However, MTUS requires 30-day rental with documentation of use and efficacy before a home unit is allowed. There is no documentation that the patient has trialed IF unit for a one-month with documentation of outcomes. This request for Interferential unit purchase is not in accordance with guideline recommendations. Therefore, the request is not medically necessary.