

Case Number:	CM15-0143901		
Date Assigned:	08/17/2015	Date of Injury:	04/01/2003
Decision Date:	10/05/2015	UR Denial Date:	07/21/2015
Priority:	Standard	Application Received:	07/24/2015

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: 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:

This 79 year old male sustained an industrial injury to the neck and back on 4-1-03. Recent treatment consisted of physical therapy for the knees, medications, trigger point injections and injections. The injured worker had a history of bilateral total knee replacements. In a PR-2 dated 6-25-15, the injured worker complained of severe neck and low back pain as well as moderate bilateral knee pain. Physical exam was remarkable for lumbar spine with positive bilateral straight leg raise, slightly decreased lower extremity strength and sensation and decreased bilateral knee range of motion. The injured worker walked with one crutch guarding his back. The injured worker had pain on the right side of his back as he ambulated. Current diagnoses included status post right knee arthroscopic debridement for meniscus tears, lumbar spine degenerative disc disease with herniated nucleus pulposus, cervical spine degenerative disc disease, left knee post traumatic arthritis, right hip osteoarthritis, left total knee replacement and status post left knee arthroscopy. A urine toxicology screening was completed during the office visit. The treatment plan included continuing physical therapy for the knees, continuing use of the X-Force with Solar Care device and renewing medications (Xanax, Prilosec, Ibuprofen and Tylenol #4).

IMR ISSUES, DECISIONS AND RATIONALES

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

One urine drug screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines urine drug screen Page(s): 43.

Decision rationale: The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. There is no documentation in the medical record that a urine drug screen was to be used for any of the above indications. Urine drug screen is not medically necessary.

One X-force with solar care: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back & Lumbar & Thoracic (Acute & Chronic) (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back & Lumbar & Thoracic (Acute & Chronic), Infrared Heat Therapy.

Decision rationale: The Official Disability Guidelines do not recommended infrared therapy over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise). Heat therapies have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Based on the patient's stated date of injury, the acute phase of the injury has passed. One X-force with solar care is not medically necessary.

Xanax 1mg #60: Upheld

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

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

Decision rationale: Xanax (alprazolam) is a benzodiazepine medication used to treat anxiety and panic disorders. The MTUS states that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Xanax 1mg #60 is not medically necessary.

Prilosec 20mg #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines proton pump inhibitor, NSAID, gastrointestinal events Page(s): 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (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. There is documentation that the patient has at least one of the risk factors needed to recommend a proton pump inhibitor. I am reversing the previous utilization review decision. Prilosec 20mg #90 is medically necessary.

Tylenol #4 #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain; Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen (Tylenol with Codeine) Page(s): 35.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that codeine is recommended as an option for mild to moderate pain. Codeine is a schedule C-II controlled substance. It is similar to morphine. 60 mg of codeine is similar in potency to 600 mg of acetaminophen. It is widely used as a cough suppressant. It is used as a single agent or in combination with acetaminophen (Tylenol with Codeine) and other products for treatment of mild to moderate pain. There is no documentation supporting any functional improvement with the continued long-term use of Tylenol #4. Tylenol #4 #90 is not medically necessary.

18 sessions of physical therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The MTUS allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Prior to full authorization,

therapeutic physical therapy is authorized for trial of 6 visits over 2 weeks, with evidence of objective functional improvement prior to authorizing more treatments. There is no documentation of objective functional improvement and the request is for greater than the number of visits necessary for a trial to show evidence of objective functional improvement prior to authorizing more treatments, therefore is not medically necessary.

Retrospective 2 bilateral C6-7 trigger point injections (DOS 6/25/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: The MTUS states that trigger point injections are recommended only for myofascial pain syndrome with limited lasting value and not recommended for radicular pain. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. Retrospective 2 bilateral C6-7 trigger point injections is not medically necessary.