

Case Number:	CM15-0149888		
Date Assigned:	08/13/2015	Date of Injury:	09/09/2011
Decision Date:	10/02/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	08/03/2015

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: New York, California
 Certification(s)/Specialty: Emergency 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 49 year old female who sustained an industrial injury on 09-09-2011 resulting in injury to the cervical and lumbar spines, both shoulders and both arms. Treatment provided to date has included: chiropractic therapy (9 sessions as of 06-05-2015); physical therapy; injections; medications; and conservative therapies and care. Recent diagnostic testing included: x-rays of the cervical spine (06-11-2015) showing multilevel moderate cervical spondylosis with satisfactory range of motion (ROM) in the cervical spine; x-rays of the thoracic spine (06-11-2015) showing moderate levoscoliosis; x-rays of the lumbar spine (06-11-2015) showing decreased disc height at L4-5 and L5-S1, and multilevel facet joint arthropathy with satisfactory ROM; MRIs of the lumbar, thoracic and cervical spines (dated 06-24-2015 and 06-25-2015); however, these exams were dated after the request for authorization was submitted. Other noted dates of injury documented in the medical record include: cumulative trauma injuries 09-09-2010 through 09-09-2011, and from 09-09-2011 through 04-17-2015. Comorbidities included high blood pressure. On 06/18/2015, physician progress report noted complaints of cervical and lumbar spine pain. The pain was rated 6 out of 20 in severity. Current medications include ketoprofen 75mg, Benazepril 40mg, and hydrochlorothiazide 12.5mg. The physical exam revealed tenderness to palpation of the cervical paraspinals extending into the bilateral lateral trapezii with active myospasms, restricted range of motion (ROM) in the cervical spine, and tenderness to palpation of the lumbar paraspinals bilaterally. The provider noted diagnoses of cervical spine musculoligamentous sprain and strain, cervicalgia, lumbago, and lumbar spine musculoligamentous sprain and strain. Plan of care includes continued or additional

chiropractic therapy; new prescriptions for: Voltaren 100mg tablets, Prilosec 20mg and transdermal analgesics; urine toxicology screening to establish a baseline for medication management; purchase of IF (interferential) unit and hot and cold therapy unit; and follow-up in 4-6 weeks. The injured worker's work status was not specified. The request for authorization and IMR (independent medical review) includes: 12 additional chiropractic therapy 2-3 times per week for 4 weeks, for the treatment of the cervical and lumbar spines; Prilosec 20mg #90; Topical transdermal #2 (capsaicin, flurbiprofen, gabapentin, menthol and camphor) applied 2-3 times daily; urine toxicology drug screening quantity 1; and purchase of IF unit, hot and cold therapy, quantity 1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy continued 2-3 times a week for 4 weeks, in treatment of the cervical and lumbar spine Qty: 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

Decision rationale: Ca MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Per the MTUS, manual therapy/manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. The MTUS recommends a trial of 6 visit over 2 weeks, and with evidence of objective functional improvement up to 18 visits over 6-8 weeks. Elective or maintenance care is not medically necessary, recurrences or flare-ups require re-evaluation of treatment success, and if return-to-work has been achieved then 1-2 visits every 4-6 months are recommended. Per the ACOEM Guideline citation above, manipulation is a treatment option during the acute phase of injury, and manipulation should not be continued for more than a month, particularly when there is not a good response to treatment. After review of the medical documentation submitted, it was determined that the injured worker had previously undergone 9 sessions of chiropractic manipulation; however, the dates of these sessions and the outcome was not provided or discussed. Elective maintenance is not medically necessary and flare-up require re-evaluation of treatment success. Therefore, the request for 12 additional chiropractic therapy 2-3 times per week for 4 weeks, exceeds these recommendations. The request is therefore determined to be not medically necessary.

Prilosec 20 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI symptoms & cardiovascular risk Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic) Chapter, PPIs.

Decision rationale: According to the California MTUS (2009), omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Upon review of the clinical documentation, the injured worker is not over the age of 65. Additionally, there is no evidence of high dose or multiple NSAID use, concurrent use of aspirin, corticosteroids, and or anticoagulants. There are no abdominal exams documented. Given the increased risk associated with PPI medications and lack of GI risk factors, the medical necessity for omeprazole (Prilosec) has not been established. Therefore, omeprazole 20mg #90 is not medically necessary.

Topical transdermal #2 (Caps/Flur/Gaba/Menth/Camp): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter; Flurbiprofen (Ansaid®).

Decision rationale: In regards to the request for topical transdermal #2 (consisting of: capsaicin, flurbiprofen, gabapentin, menthol and camphor), the CA MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. According to the MTUS guidelines: Topical Analgesic are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The MTUS goes on to specify that gabapentin is "not" recommended, as there is no peer-reviewed literature to support its use. Flurbiprofen is a NSAID (non-steroidal anti-inflammatory drug) used to treat osteoarthritis and mild to moderate pain. However, it is not recommended for use in the topical form, as diclofenac is the only FDA-approved topical NSAID at this time. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. After review of the clinical notes and the request for authorization, it was noted that the transdermal analgesic requested contains several ingredients that are not recommended by the MTUS or ODG for topical use. In addition, it was noted that the specific formulation was not indicated; therefore, this is not a valid request, and the topical transdermal #2 (consisting of: capsaicin, flurbiprofen, gabapentin, menthol and camphor) is not medically necessary.

Urine drug screen Qty:1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing, & Criteria for use of Opioids Page(s): 43, & 76-96.

Decision rationale: According to the MTUS guidelines, urine drug testing (UDT) can be used to assess for misuse of prescribed medications, and the presence of non-prescribed or illegal drugs. There are two different types of UDT: 1) Screening Assays, and 2) Confirmatory testing. Per the ODG, "screening assays are based on immunoassays, which can be either laboratory-based or point-of-collection testing (POC). POC testing is also commonly referred to as "dip-stick" testing. This latter type of testing is performed on-site and usually requires no instrumentation." Confirmatory testing is laboratory based testing which can identify and quantify specific drugs. The MTUS and ODG do not specify the recommended frequency of urine drug testing. However, the ODG states that "When the POC screen is appropriate for the prescribed drugs without evidence of non-prescribed substances, confirmation is generally not required. Confirmation should be sought for: (1) all sample testing negative for prescribed drugs, (2) all samples positive for non-prescribed opioids, and (3) all samples positive for illicit drugs". Additionally, the ODG recommends UDT: 1) at the onset of treatment of a new patient who is already using opioids; 2) in cases where a patient ask for a specific drug, refuses generic forms, or refuses changes in scheduled drugs or other treatments; 3) if the patient has a positive "at risk" screening on file; or 4) if aberrant behavior or misuse is suspected or detected. In this case, the injured worker has presented for a flare-up of cervical and lumbar spine pain. There is no evidence that the injured worker: 1) is or is possibly using illicit drugs; 2) already taking opioid drugs; 3) asking for a specific opioid; 4) has a positive "at risk" screening; or 5) is exhibiting aberrant behaviors. Additionally, the injured worker was not in the process of initiating opioid therapy, and there were no positive findings on a screening assay that required confirmation testing. Therefore, the urine drug screening is not medically necessary.

IF, hot and cold unit purchase Qty:1: 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) Low Back - Lumbar & Thoracic (Acute & Chronic); Interferential therapy & Pain (chronic) Chapter; Interferential current stimulation (ICS).

Decision rationale: MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. The MTUS is silent in regards to Interferential (IF) units; therefore alternative guidelines were used in the review of this request. According to the ODG, IF therapy or current stimulation is generally not recommended as there is insufficient evidence of their effectiveness. Additionally, they are not recommended as an isolated intervention as there no quality evidence of effectiveness except in conjunction with recommended treatments which include return to work, exercise and medications. Even with these additionally modalities, there is limited

evidence of improvement. Furthermore, the ODG states that although they have been proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. Upon review of the clinical notes, the physician requested an IF unit for home use; however, the site of application was not indicated. IF therapy is generally not recommended due to the lack of evidence to support its effectiveness. Therefore the request for the purchase of an IF unit for home use is not medically necessary.