

Case Number:	CM15-0170552		
Date Assigned:	09/11/2015	Date of Injury:	04/08/1997
Decision Date:	10/29/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	08/31/2015

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, Pain Management

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 55 year old male, who sustained an industrial injury on April 8, 1997. The injury occurred while the injured worker was chopping ice. The injured worker experienced neck and left upper extremity pain due to repetitive use. The diagnoses have included cervical disc displacement, cervical spondylosis, chronic pain syndrome, myofascial pain, cervical discogenic pain, cervical facet pain, cervical radicular pain, thoracic spine pain, lumbar discogenic pain and depression due to chronic pain. The injured worker was noted to be permanent and stationary. The current work status was not identified. Current documentation dated July 28, 2015 notes that the injured worker reported constant neck pain with radiation to the left upper extremity and down into the third, fourth and fifth fingers on the left hand. The pain was rated a 7-9 out of 10 without medications. The injured worker also noted low back pain with radiation to the left lateral lower leg. The pain was described as a burning pain. Examination of the cervical spine revealed tenderness on the left and moderate spasm in the paraspinal and trapezius muscles on the left. Range of motion was decreased in all directions. A Spurling's sign was positive on the left. Thoracolumbar spine examination revealed tenderness and moderate spasm in the paraspinal muscles on the left. Range of motion was full but painful. Sensation was decreased over the fourth and fifth fingers on the left hand and decreased over the lateral aspect of the left lower extremity. Treatment and evaluation to date has included medications, radiological studies, MRI, physical therapy, acupuncture treatments, psychiatric evaluations, psychological evaluations, spinal cord stimulator, massage therapy a transcutaneous electrical nerve stimulation unit and a cervical fusion. The injured worker had pain relief with the

physical therapy, acupuncture treatments and massage therapy. Treatments tried and failed include cervical epidural steroid injections, spinal cord stimulator, a transcutaneous electrical nerve stimulation unit and a cervical fusion. Medications tried and failed include Norco, Vicodin, Oxycodone, methadone and Gabapentin. A MRI of the lumbar spine (3-10-2015) showed lumbar disc protrusions. Cervical spine MRI (6-20-2014) showed no evidence of significant disc herniation or protrusions. No spinal stenosis was identified. Current medications include Brintellix, Aripiprazole and Silenor. The treating physician's request for authorization dated July 31, 2105 included requests for outpatient physical therapy for the neck and low back 1 time a week for 6 weeks, massage therapy for the neck and low back 1 time a week for 6 weeks, transportation to a psychotherapy appointment and follow-up appointments, Duragesic patches 12 mcg # 10 and Lyrica 50 mg # 90. The original Utilization Review dated August 7, 2015 non-certified the request for outpatient physical therapy for the neck and low back 1 time a week for 6 weeks due to the injured worker having had prior physical therapy and it is unclear as to why the injured worker would not be independent in self-care. Utilization Review non-certified massage therapy for the neck and low back 1 time a week for 6 weeks due to lack of documentation in the medical records of objective functional benefit from the prior sessions and it is unclear if the massage therapy is being proposed as an adjunct to other treatment. Utilization Review non-certified transportation to a psychotherapy appointment and follow-up appointments due to unclear documentation that the injured workers impairment reached a level of disability preventing him from self-transport. Utilization Review non-certified the request for Duragesic patches 12 mcg # 10 due to lack of documentation of a change in diagnosis, medications the injured worker was taking, what treatments have been tried since the use of opioids and no documentation of pain and functional improvement as compared to base line. Utilization Review non-certified the request for Lyrica 50 mg # 90 due to lack of documentation of postherpetic neuralgia and painful polyneuropathy conditions for which the medication is recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient PT for The Neck and Low Back 1x6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy Neck & Upper Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of

completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

Massage Therapy for The Neck and Low Back 1x6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy.

Decision rationale: Regarding the request for massage therapy, Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, there is no indication as to the number of massage therapy visits the patient has previously undergone. Furthermore, there is no documentation of objective functional improvement from the therapy sessions already authorized. Additionally, it is unclear exactly what objective treatment goals are hoping to be addressed with the currently requested massage therapy. In the absence of clarity regarding those issues, the currently requested massage therapy is not medically necessary.

Transportation to Psychotherapy Appointment and Follow Up Appointments: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation California Department of Health Care Services, California Code of Regulations [CCR], Title 22, Section 51323. Policy on Medical Transportation.

Decision rationale: Regarding the request for transportation for this injured worker, the California MTUS and ODG do not address this issue. The California Department of Health Care Service cover "ambulance and other medical transportation only when ordinary public or private conveyance is medically contra-indicated and transportation is required for obtaining needed medical care." Within the documentation available for review, there is no clear rationale identifying why other forms of private and/or public conveyance are contraindicated. In light of the above issues, this request is not medically necessary.

Duragesic Patches 12 MCG #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids (Classification), Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Regarding the request for Duragesic (fentanyl), Chronic Pain Medical Treatment Guidelines state that fentanyl is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Regarding the use of Fentanyl, guidelines state that it should be reserved for use as a second-line opiate. Within the documentation available for review, there is indication that the medication is improving the patient's pain from 7/10 to 5/10 and documentation of failure of first line therapy. However, there is no documentation of specific examples of functional improvement, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Duragesic (fentanyl), is not medically necessary.

Lyrica 50 MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Regarding request for pregabalin (Lyrica), Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the currently requested pregabalin (Lyrica) is not medically necessary.