

Case Number:	CM15-0173183		
Date Assigned:	09/18/2015	Date of Injury:	08/03/2011
Decision Date:	10/29/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/02/2015

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

Certification(s)/Specialty: Anesthesiology

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 60 year old female who sustained an industrial injury on 8-3-11. Diagnoses noted are cervical discogenic disease with radiculitis, chronic cervical spine sprain-strain, bilateral cervical radiculopathy, cervical facet arthrosis, lumbar discogenic disease, history of lumbar spondylolisthesis L5-S1 grade I-II, chronic low back pain, left shoulder impingement syndrome with subacromial bursitis, bilateral knee anterior cruciate ligament tears with valgus deformity bilaterally- right knee greater than left knee, herniated nucleus pulposus C5-C6 to C6- C7, status post C5-C7 fusion 9-27-13, and status post right total knee arthroplasty. Previous treatment includes lumbar epidural steroid injection, physical therapy, medication, and activity modification. In a progress report dated 7-7-15, the physician notes chief complaints of cervical spine pain, low back pain, left shoulder pain, and bilateral knee pain. She is status post right total knee arthroplasty and is overall better and will begin knee therapy this week. She had excellent relief with her lumbar epidural, 70-80% for several weeks. It is noted she has low back pain and lumbar radicular pain and that the cause of the radicular pain is due to lumbar spinal stenosis as per imaging studies, history and physical exam. With the use of medications, her level of function improves and she is able to do light housework, laundry, walk and drive. Depression and anxiety attacks are noted with a plan to refer to psych. Exam of the cervical spine reveals decreased range of motion and tenderness to palpation over the cervicotracheal ridge and spasm in the neck. The left shoulder reveals positive impingement on the right. The lumbar spine is noted for spasm and decreased sensation- L5 bilaterally. Straight leg raise is positive at 90 degrees bilaterally. Right knee range of motion is 80 degrees- flexion and 10

degrees- extension. There is joint pain of the left knee. She remains temporarily totally disabled. The requested treatment of Norco 10-325mg #90 was modified to #60 and Neurontin 600mg #90 was modified to #60 on 8- 21-15. The requested treatment of a referral to a psychologist, Colace 100mg #90, Celexa 20mg #30, Celebrex 200mg #60, bilateral L4-S1 epidural steroid injection, and physical therapy twice weekly for 6 weeks to the right knee x12 was denied on 8-21-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral to a psychologist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, pg. 127.

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

Decision rationale: According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity for the requested Psychology consultation. There is limited evidence of any current significant psychological complaints aggravated by the current injury that causes functional limitations and deficits. There is also no documentation that diagnostic and therapeutic management have been exhausted within the present treating provider's scope of practice. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Norco 10/325mg, #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): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. There is no documentation of significant pain relief or increased function from the opioids used to date. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Neurontin 600mg, #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): Anti-epilepsy drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Anti-epilepsy drugs (AEDs), Gabapentin (Neurontin).

Decision rationale: According to the CA MTUS (2009) and the ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. The records documented that this patient has neuropathic pain; however, there is no documentation of subjective or objective functional improvement in her condition with the use of this medication. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

Colace 100mg, #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 Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: Opioid-induced constipation is a common adverse effect of long-term opioid use because of the binding of opioids to peripheral opioid receptors in the gastrointestinal tract, resulting in absorption of electrolytes and reduction in small intestine fluid. Colace is a stimulant laxative and is used to relieve occasional constipation. According to the ODG, if opioids are determined to be appropriate for the treatment of pain then prophylactic treatment of constipation should be initiated. In this case, it has been recommended that the patient wean from opiate therapy. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Celexa 20mg, #30: 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: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain, SSRIs (selective serotonin reuptake inhibitors). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Anti-depressants.

Decision rationale: Citalopram (Celexa) is a selective serotonin re-uptake inhibitor (SSRI). SSRIs are not recommended as a treatment for chronic pain, but may have a role in treating secondary depression. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain, but more information is needed regarding the role of SSRIs and pain. In addition, SSRIs have not been shown to be effective for low back pain. In this case, there is no specific documentation of depression, anxiety, or stress related medical complaints arising from the industrial injury. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Celebrex 200mg, #60: 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): NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Celebrex (Celecoxib) is a nonsteroidal anti-inflammatory drug (NSAID) that is a COX-2 selective inhibitor, a drug that directly targets COX-2, an enzyme responsible for inflammation and pain. Unlike other NSAIDs, Celebrex does not appear to interfere with the antiplatelet activity of aspirin and is bleeding neutral when patients are being considered for surgical intervention or interventional pain procedures. Celebrex may be considered if the patient has a risk of GI complications, but not for the majority of patients. Generic NSAIDs and COX-2 inhibitors have similar efficacy and risks when used for less than 3 months. In this case, there is no documentation of the medication's pain relief effectiveness or functional improvement, as compared to functionality using a non-prescription anti-inflammatory medication. The medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Bilateral L4-S1 epidural steroid injection: 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): Epidural steroid injections (ESIs).

Decision rationale: Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Research has shown that, on average, less than two injections are required for a successful ESI

outcome. ESIs can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. CA MTUS guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, the patient received a previous lumbar ESI with improvement of low back pain, however there were no objective functional gains documented as a result of the prior epidural steroid injection. Medical necessity for the requested services has not been established. The requested bilateral L4-S1 epidural steroid injections are not medically necessary.

Physical therapy, twice weekly for 6 weeks, to the right knee, x12: 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) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient has had prior physical and there is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the additional 12 PT (2x6) sessions requested. Medical necessity for the additional PT visits requested has not been established. The requested services are not medically necessary.