

Case Number:	CM15-0038730		
Date Assigned:	03/09/2015	Date of Injury:	03/18/2009
Decision Date:	06/04/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	03/02/2015

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: Pediatrics, Internal 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 (IW) is a 43-year-old female who sustained an industrial injury on 03/18/2009. Diagnoses include lumbosacral radiculopathy and lumbar sprain. Treatment to date has included medications and therapy in the past. A physician progress note dated 01/27/2015 documents the injured worker complains of chronic lumbar spine pain with associated radiating pain into the bilateral lower extremities, more on the right, along with weakness, and associated with numbness. Pain is described as constant, achy, and it radiates down both legs. She has occasional spasms, and pain is rated 4 out of 10, and range of motion is restricted. She has positive paraspinal tenderness and positive right sciatica nerve stretch test. She has subjective left and right radiculopathy. Treatment requested is for Chiropractic manipulation (12 sessions), Acupuncture (12 sessions), Labs: CBC, CRP, CPK, Chem 8 and hepatic/arthritis panel, TENS unit with supplies, Urine drug screen, and Voltaren Gel 1.3% #100. On 02/05/2015, Utilization Review partially certified the request for Labs: CBC, CRP, CPK, Chem 8 and hepatic/arthritis panel to 1 hepatic panel between 01/27/2015 and 04/03/2015 and cited was non-MTUS Guidelines-National Guideline Clearinghouse. The request for 12 sessions of Chiropractic manipulation is not certified and cited was CA MTUS Guidelines. Acupuncture 12 sessions was not certified and cited was CA MTUS Guidelines. The request for TENS Unit with supplies was not certified and cited was CA MTUS Guidelines. A Urine Drug Screen was denied and cited was ODG. The request for Voltaren Gel 1.3% #100 was denied and cited was CA MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Labs: CBC, CRP, CPK, Chem 8 and Hepatic/Arthritis Panel: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Monitoring of Liver Chemistry with Medication Use - Monitoring Patients on a Potentially Hepatotoxic Drug - Medical Services Commission. Abnormal liver chemistry - evaluation and interpretation. Victoria (BC): British Columbia Medical Services Commission; 2011 Aug 1.5 p.).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s): 7.

Decision rationale: Using medications in the treatment of pain requires a thorough understanding of the mechanism underlying the pain as well as to identify comorbidities that might predict an adverse outcome. As stated on page 47 of the ACOEM Practice Guidelines, consideration of comorbid conditions, side effects, cost, and efficacy of medication versus physical methods and provider and patient preferences should guide the physician's choice of recommendations. Choice of pharmacotherapy must be based on the type of pain to be treated and there may be more than one pain mechanism involved. The physician should tailor medications and dosages to the individual taking into consideration patient-specific variables such as comorbidities, other medications, and allergies. The physician should be knowledgeable regarding prescribing information and adjust the dosing to the individual patient. According to the documentation, the IW has no known medical comorbidities and thus laboratories prior to initiation of medication would not be medically necessary.

TENS Unit with Supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy; TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-115.

Decision rationale: Per MTUS guidelines, TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for neuropathic pain, phantom limb pain, spasticity and multiple sclerosis. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. The IW has none of the conditions as an indication for TENS usage and is not doing physical therapy and thus the request is not medically reasonable and appropriate.

Voltaren Gel 1.3% #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs (NSAIDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Topical NSAIDs, like diclofenac, are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. According to the documentation, the IW's complaints are of lower back pain and radicular symptoms but no osteoarthritis of the small joints. This request is not medically necessary and appropriate.

Chiropractic manipulation (12 sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter - Manipulation.

Decision rationale: Per MTUS guidelines manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. With regards to the low back a therapeutic trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care is not medically necessary. With recurrences/flare-ups, treatment success needs to be reevaluated, if RTW achieved then 1-2 visits every 4-6 months. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. Maximum duration: 8 weeks. The ODG Chiropractic Guidelines: Therapeutic care: Mild: up to 6 visits over 2 weeks, Severe: Trial of 6 visits over 2 weeks. Elective/maintenance care is not medically necessary. With recurrences/flare-ups treatment success needs to be reevaluated, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care. The IW is described to have 4/10 pain and has returned to work. There is no documentation as to how many sessions the IW had received in the past and no acute exacerbation is noted. This request is not medically necessary.

Acupuncture (12 sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

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 Chapter-Acupuncture.

Decision rationale: ODG Acupuncture Guidelines recommend an initial trial of 3-4 visits over 2 weeks. With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks. The request is not medically necessary as written, as it is for greater than the initial trial period.

Urine Drug Screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines urine drug test - opioids, substance abuse (tolerance, dependence, addiction). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Pain Treatment Agreement Page(s): 89.

Decision rationale: According to MTUS guidelines, IW's treated with opioids may be required to sign a pain treatment agreement. Part of the agreement may include urine screening for medication and illicit substances. No pain management agreement was submitted stating urinalysis was required and there was no notation of irregular behavior suggesting abuse. This request is not medically necessary and appropriate.