

Case Number:	CM13-0001947		
Date Assigned:	12/11/2013	Date of Injury:	12/11/2011
Decision Date:	01/15/2014	UR Denial Date:	07/05/2013
Priority:	Standard	Application Received:	07/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 42 year old male patient who reported an injury on 12/11/2011. The mechanism of injury was a fall from a tree approximately 15 feet. The most recent clinical note dated 11/01/2013 reported the patient did have history of injuries to his back to include fractures. The patient denied numbness or tingling to extremities at time of examination. The patient complained of pain and soreness in his back and right wrist which increase at night. Physical assessment revealed no soft tissue swelling, masses, lesions, or atrophy to lumbar spine. The patient demonstrated limited lumbar range of motion, and full motor strength and range of motion to bilateral lower extremities. The patient demonstrated good grasp, pinch, and strength with apposition. Motor strength in wrist and hand were 5/5 throughout. There was positive Tinel's, and all other testing were negative findings. Right carpal tunnel release was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze 32oz. between 6/12/2013 and 8/30/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

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 and Thoracic Spine, Biofreeze cryotherapy gel.

Decision rationale: Official Disability Guideline recommended Biofreeze as an optional form of cryotherapy for acute pain. The patient's back pain is a chronic condition that has affected him since 2011. As such the request for Biofreeze 32oz between 06/12/2013 and 08/30/2013 is non-certified.

Vicodin 7.5/300mg #200 with 5 refills between 6/12/2013 and 12/28/2013: 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 Opioids Page(s): 75-91.

Decision rationale: There is no documented difference in the patient's pain level when taking the Vicodin 7.5/300mg in comparison to when he is not taking the medication. No detailed pain assessments with documented pain levels pre and post taking said medication. As such it is not apparent whether or not the current pain medication regimen is even effective. California MTUS guidelines state reported ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life Information from family members or other caregivers should be considered in determining the patient's response to treatment. None of the recommended information is provided in the medical record. As such the request for Vicodin 7.5/300mg #200 is non-certified.

TENS unit between 6/12/2013 and 8/30/2013: 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 Transcutaneous Electrotherapy Page(s): 114-116.

Decision rationale: California MTUS guidelines state TENS are not recommended as a primary treatment modality, but a one month home based trial may be considered. Documentation of pain of at least three months duration is required and there should be evidence that other appropriate pain modalities have been tried (including medication) and failed. There is no information provided regarding the patient's response to the TENS unit and did not indicate a three month trial had previously been accomplished. As such, the request for TENS unit between 06/12/2013 and 08/30/2013 is non-certified.

