

Case Number:	CM13-0009804		
Date Assigned:	09/17/2013	Date of Injury:	02/04/2010
Decision Date:	01/13/2014	UR Denial Date:	07/24/2013
Priority:	Standard	Application Received:	08/12/2013

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 Ohio and Pennsylvania. 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:

This patient is a 40-year-old woman. Her underlying date of injury is 02/04/2010. The initial mechanism of injury is not described in the initial reviewer report, although it is described in the doctor's first report as, "Individual was being assisted to wheelchair, became combative and struck me on right arm/shoulder with closed fist, back pain, dizziness, severe pain to shoulder area." The patient's treating diagnoses included cervical sprain superimposed upon degenerative changes at multiple levels in the cervical spine, right shoulder tendinitis, and lumbar sprain superimposed upon a herniated nucleus pulposus at L5-S1. An initial review recommended non-certification of physical therapy with the rationale that there was no mention of prior therapy or derived benefit from such treatment. A large wall back pillow and a large leg wedge pillow were non-certified given lack of information to establish medical necessity. Maintenance massage therapy was partially certified, noting that it at least six sessions had been completed. Flexeril was partially certified with the rationale that it was not indicated but it would be ill advised to stop the drug abruptly. Norco was partially certified given the lack of documented benefit. A lumbar brace was certified given a history of spondylolisthesis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Maintenance massage therapy for lumbar/cervical spine x6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Massage therapy Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Section on Massage Page(s): 60.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state that massage is a passive intervention and treatment dependence should be avoided. This guideline does not support indication for massage in the current chronic setting. Therefore, maintenance treatment is not medically necessary.

Flexeril 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines, Section on Muscle Relaxants, states that Flexeril is recommended for a short course of therapy and that there is no recommendation for chronic use. The medical records do not provide an alternate rationale for the use of this medication in the current chronic setting. Therefore, this treatment is not medically necessary.

Restoril 30mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines, Section Pain/Insomnia Treatment.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state that chronic benzodiazepines are the treatment of choice in very few conditions and are not recommended for chronic use. Additionally, the Official Disability Guidelines/Pain/Insomnia Treatment does not support the use of this medication in the chronic setting. Therefore this treatment is not medically necessary.

Norco 5/325 mg # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 89.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid/Ongoing Management Page(s): 78.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines recommend the use of opioids only with clear documentation of functional benefit and monitoring of the four domains of opioid management. The medical records do not contain such information. Therefore, this request is not medically necessary.

Physical therapy right shoulder (unknown quantity/duration): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines recommend fading of treatment frequency plus active self-directed home physical medicine. These guidelines anticipate that this patient would have transitioned by now to an independent home rehabilitation program. The medical records do not provide an alternative rationale to support the use of this treatment in a chronic setting.

Large leg wedge pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Pillows and Cushions; Number 0456 Policy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg/Durable Medical Equipment.

Decision rationale: The California Medical Treatment Guidelines do not specifically address/suggest the type of pillow requested. However, principles from other guidelines apply and can be applied in this case. This request appears in part to be aimed at treating low back pain as a form of lumbar support. I note that ACOEM Guidelines Chapter 12, Low Back, page 301 states "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." The medical records and guidelines do not provide additional basis for concluding that the requested pillow would be a more effective form of lumbar support than those upon which the ACOEM Guidelines were based. In general principal, Official Disability Guidelines/Knee and Leg/Durable Medical Equipment includes criteria for durable medical equipment which include the definitions "Is primarily and customarily used to serve a medical purpose . . . Generally is not useful to a person in the absence of illness or injury." The medical records and guidelines do not provide a basis to conclude that the requested pillow is primarily and customarily used to serve a medical purpose. Rather, it appears that this device would be useful to a person in the absence of illness or injury. For these multiple reasons, the requested pillow is not reasonable and medically necessary

Large wall back pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Pillows and Cushions; Number 0456 Policy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg/Durable Medical Equipment.

Decision rationale: The California Medical Treatment Guidelines do not specifically address/suggest the type of pillow requested. However, principles from other guidelines apply and can be applied in this case. This request appears in part to be aimed at treating low back pain as a form of lumbar support. I note that ACOEM Guidelines Chapter 12, Low Back, page 301 states "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." The medical records and guidelines do not provide additional basis for concluding that the requested pillow would be a more effective form of lumbar support than those upon which the ACOEM Guidelines were based. In general principal, Official Disability Guidelines/Knee and Leg/Durable Medical Equipment includes criteria for durable medical equipment which include the definitions "Is primarily and customarily used to serve a medical purpose . . . Generally is not useful to a person in the absence of illness or injury." The medical records and guidelines do not provide a basis to conclude that the requested pillow is primarily and customarily used to serve a medical purpose. Rather, it appears that this device would be useful to a person in the absence of illness or injury. For these multiple reasons, the requested pillow is not reasonable and medically necessary