

Case Number:	CM13-0039539		
Date Assigned:	12/20/2013	Date of Injury:	05/23/2013
Decision Date:	03/05/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	10/28/2013

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 Family Medicine and is licensed to practice in Arizona. 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 37 year old female with date of injury on 5/20/2013. The patient is being treated for ongoing back pain sustained from a fall. Diagnoses include lumbar sprain, strain, sacroiliac joint sprain, radiculitis, and annular disc tear L4-L5. The patient was initially prescribed Norco and Soma. The medications were later adjusted to Norco, Fexmid, and ibuprofen. A MRI was performed which noted an annular tear and disc bulge at L5. The patient treatments have included medication and physical therapy. Subjective complaints include mid to low back pain with radiation to the buttocks, right worse than left. Also stomach upset, nausea and constipation due to medication use. The physical exam shows muscle guarding over lumbar paraspinal muscles with tenderness over right sacroiliac joint, positive leg raise on the left. No weakness, no sensory changes noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 41-42, 63.

Decision rationale: CA MTUS guidelines indicate that the use of cyclobenzaprine should be used as a short term therapy and the effects of treatment are modest and may cause adverse affects. This patient had been using muscle relaxers since onset of injury which is longer than the recommended course of therapy of 2-3 weeks. Furthermore, muscle relaxers in general show no benefit beyond NSAIDS in pain reduction of which the patient was already taking. There is no evidence in the documentation that suggests the patient experienced improvement with the ongoing use of cyclobenzaprine. Due to clear guidelines suggesting cyclobenzaprine as short term therapy and no clear benefit from adding this medication the requested prescription for cyclobenzaprine is not medically necessary.

Norco 2.5/ 325 mg # 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The patient in question has been on chronic opioid therapy. CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. Guidelines for chronic back pain indicate that while opioid therapy can be efficacious it is limited to short term pain relief and long term efficacy (>16 weeks) is unclear, and failure to respond to limited course of medication suggests reassessment and consideration for alternative therapy. Furthermore, no documentation is presence of MTUS opioid compliance guidelines, including risk assessment, attempt at weaning, updated urine drug screen, and ongoing efficacy of medication. For this patient, there is no demonstrated improvement in pain or function from long-term use. For these reasons, the requested Norco is not medically necessary.

Chiropractic sessions: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 57-58.

Decision rationale: CA MTUS recommends manual therapy and manipulation for chronic pain if caused by musculoskeletal conditions. Manual medicine is intended to achieve positive symptomatic or objective gains in function and progression of a therapeutic exercise program. This patient has pain and spasm related to a musculoskeletal condition. Specifically, CA MTUS suggests a therapeutic trial of 12 visits. This therapeutic trial of chiropractic is medically necessary to attempt to improve functional gains.

Orthostim 4 unit and supplies (rental or purchase): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Units Page(s): 114-115.

Decision rationale: CA MTUS guidelines do not support interferential current stimulation as an isolated intervention. Quality evidence of efficacy is limited even in conjunction with treatments, including return to work, exercise and medications. A TENS (transcutaneous electrical nerve stimulation) unit is only recommended for a one month trial in conjunction with other modalities. There is no evidence submitted of improvement in function as a result of prior use of this device. Galvanic stimulation and neuromuscular stimulation is not supported. The request device includes NMES and galvanic stimulation, and if the components of a unit are not supported, there is lack of support for the whole unit. Due to these reasons this Orthostim unit is not medically necessary

Thermophore: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: ACOEM guideline suggests that physical treatments such as diathermy, cutaneous laser, and ultrasound have no proven efficacy in treating low back pain. For this patient, there is no submitted evidence that usage of this unit has increased her functional status, or a decrease in medication use. For these reasons, the medical necessity of this unit is not established.