

Case Number:	CM13-0065510		
Date Assigned:	01/03/2014	Date of Injury:	07/21/2010
Decision Date:	04/18/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/13/2013

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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/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 57-year-old female who reported an injury on 07/21/2010 due to an altercation with a patient. The patient reportedly sustained an injury to her low back. The patient's treatment history included physical therapy, acupuncture, trigger point injections, epidural steroid injections, occipital nerve injections, and chiropractic care. The patient's most recent clinical evaluation documented that the patient had continued cervical spine pain with restricted range of motion secondary to pain, a positive Spurling's test, palpable trigger points in the right trapezius and rhomboids with tenderness to palpation in the cervical paraspinal musculature. Evaluation of the lumbar spine documented that the patient had tenderness to palpation of the lumbar paravertebral musculature with restricted range of motion secondary to pain and decreased sensation in the left lower extremity. The patient's diagnoses included neck pain, status post sprain/strain, right cervical radiculopathy, and low back pain. The patient's treatment plan included continuation of medications, low back brace, and an interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

LSO BRACE QTY: 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004)

Decision rationale: The requested LSO brace is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do not support the use of a back brace for chronic back pain. The clinical documentation submitted for review does not provide any exceptional factors to support extending treatment beyond guideline recommendations. As such, the requested LSO brace, QTY: 1.00 is not medically necessary or appropriate.

INTERFERENTIAL UNIT QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

Decision rationale: The requested interferential unit, QTY: 1.00 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends an interferential unit for patients who are participating in a functional restoration program that would benefit from an adjunct therapy such as an interferential unit. It is also recommended that these patients have failed all other treatment modalities for chronic pain to include physical therapy and a TENS unit. California Medical Treatment Utilization Schedule recommends a 30-day home trial that provides functional benefit and pain relief for these patients. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to a TENS unit. Additionally, there is no documentation that the patient has undergone a 30-day home trial providing significant pain relief and functional benefit. The request as it is written does not clearly identify whether the request is for rental or purchase. Therefore, the appropriateness of this request cannot be determined. As such, the requested interferential unit QTY: 1.00 is not medically necessary or appropriate.

SOLAR CARE FIR HEATING SYSTEM QTY: 1.00: 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-TWC): Low Back0 Lumbar & Thoracic, Infrared Therapy (IR)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004)

Decision rationale: The requested solar care FIR heating system is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends the application of hot and cold packs in the management of acute and chronic low back and upper back pain. The clinical documentation submitted for review does not provide any evidence

that the patient has failed to respond to self-managed and self-directed hot and cold pack application and requires a more intense type of therapy. As such, the requested solar care FIR heating system is not medically necessary or appropriate.

FLEXERIL 7.5MG QTY: 120.00: Upheld

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

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

Decision rationale: The requested Flexeril 7.5 mg QTY: 120.00 are not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of muscle relaxants for moderate to severe chronic pain and muscle spasms for short durations of treatment. California Medical Treatment Utilization Schedule does not recommend a treatment duration of muscle relaxants to exceed 2 to 3 weeks. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 05/2013. This exceeds California Medical Treatment Utilization Schedule recommendations. There are no exceptional factors noted to extend treatment beyond guideline recommendations. As such, the requested Flexeril 7.5 mg QTY: 120.00 are not medically necessary or appropriate.

CYCLO/KETO/LIDO CREAM 240GM QT: 2.00: Upheld

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

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

Decision rationale: The requested Cyclobenzaprine/Ketoprofen/Lidocaine cream 240 gm QT: 2.00 are not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the use of cyclobenzaprine as a topical analgesic as there is little scientific evidence to support the efficacy and safety of this type of treatment. Additionally, California Medical Treatment Utilization Schedule does not recommend ketoprofen or lidocaine in a cream formulation, as these medications are not FDA approved to treat neuropathic pain in cream or gel formulations. California Medical Treatment Utilization Schedule recommends that any medication that contains at least 1 drug or drug class that is not supported by guideline recommendations is not recommended. As such, the requested Cyclobenzaprine/Ketoprofen/Lidocaine cream 240 gm QT: 2.00 are not medically necessary or appropriate.