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| Case Number: | CM14-0004289 | | |
| Date Assigned: | 01/29/2014 | Date of Injury: | 09/24/2013 |
| Decision Date: | 06/19/2014 | UR Denial Date: | 01/03/2014 |
| Priority: | Standard | Application Received: | 01/06/2014 |

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 Orthopedic Surgery 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 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 injured worker is a 41-year-old female, who was injured in September 24, 2013. The records reflect that the mechanism of injury was intervening into a fight where the injured employee fell, reporting a neck and back injury. The low back pain was reported to be moderately severe. The initial physical examination noted a decreased range of motion to the lumbar spine. The cervical complaints were described as dull. Also noted was left wrist pain. The injured employee is noted to be 5 foot inches and 214 lbs. Muscle tenderness and spasms are reported in the neck associated with a slight decrease in range of motion. The lumbar spine injury noted weakness or significant physical examination findings. The left wrist reported no deformity or range of motion loss. Plain films did not note any acute osseous abnormalities. The diagnosis was reported as pain in the neck and lumbar strain. Physical therapy was carried out. Chiropractic care was also sought. The follow-up examination was unchanged and no overt changes were noted. Upper extremity and lower extremity motor and sensory are intact. Twelve sessions of physical therapy were completed. The most current clinical assessment noted the straight leg raise to be negative, some tenderness over the lower gluteal muscle, and normal lumbar flexion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy; Eight (8) Sessions (2 Times 4): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288.

Decision rationale: When noting the date of injury, the injury sustained, the findings on physical examination and the lack of any indicators of a neurologic compromise, there is no data presented to suggest that additional physical therapy is warranted. As noted in the Medical Treatment Utilization Schedule, a short course of physical therapy and a home exercise protocol can be supported. It is noted that twelve sessions of physical therapy have been completed, and a full range of motion lumbar spine and negative straight leg raise are noted. As such, there are little, if any gains to be made at this time. Any gains could easily be accomplished with a home exercise protocol. Therefore, based on the information presented, this request is not medically necessary and appropriate.

Orthostim IV with Conductive L/S Garment: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 117.

Decision rationale: This is an individual who was injured several months ago, is doing really well with conservative modalities and there is no indicator of any specific pain generator or neurologic optimization requiring such a device. Furthermore, the standard noted in the Medical Treatment Utilization Schedule (MTUS) is that Orthostim IV with conduction are not for isolated intervention and it does not appear that any other modalities are employed. Therefore, based on this limited clinical information, this request is not medically necessary and appropriate.

Norco (Hydrocodone/APAP 2.5/325mg); I PO Q12H PRN Pain #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 80.

Decision rationale: This is a nine-month old soft tissue myofascial strain injury without any objectification of significant pain generator. As outlined in the Medical Treatment Utilization Schedule (MTUS), this medication is a short acting opioid indicated for acute use. The efficacy for chronic back pain is limited and as such, should not be employed after 16 weeks from the date of injury. Therefore, based on the data presented for review, there is insufficient information to support the ongoing use of this preparation. This is not medically necessary.

Robaxin 750mg; 1-2 PO TID PRN #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS, Chronic Pain Medical Treatment Guidelines Page(s): 209.

Decision rationale: As with any muscle relaxant medication, the indications are short-term for acute muscle spasm. Noting the date of injury and the current physical examination, there is no objectification that other condition exists. Therefore, based on the limited clinical information presented, there is insufficient information to support the use of a muscle relaxant medication. The request is not medically necessary and appropriate.