

Case Number:	CM14-0010874		
Date Assigned:	02/21/2014	Date of Injury:	05/06/2008
Decision Date:	07/11/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/27/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, 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 45-year-old with a date of injury of May 6, 2008. The injured worker is noted to have subjective complaints of daily neck pain and stiffness with occasional radiating pain to the upper extremities and shoulders. He also has chronic low back pain with moderate to severe pain radiation into the right leg, associated with numbness. The note indicates the injured worker underwent lumbar surgery with fusion, but did not get better. Additionally, he is diagnosed with right shoulder impingement (with restricted movements), psychiatric disorder, and multiple head surgeries for hemangiomas. Current medications include Motrin, Fexmid, Norco and Prilosec. Relevant objective findings included cervical and lumbar spine tenderness to palpation over paraspinals with myospasm, positive axial compression and shoulder depression tests. Cervical range of motion was: flexion 36, extension 18, side bending R/L 52/62, rotation R/L 26/21. Lumbar range of motion was: flexion 28, extension 10, side bending R/L 13/12. Hypoesthesia was observed along bilateral L5 & S1 dermatomes. The provider had previously requested prescriptions for Fexmid 7.5mg # 60 (non-certified), Norco 2.5/325mg # 60 (modified to # 48 for gradual weaning), shower chair (non-certified) and spinal cord stimulator (non-certified).

IMR ISSUES, DECISIONS AND RATIONALES

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

FEXMID 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 Cyclobenzaprine Page(s): 41, 64.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, antispasmodics are used to decrease muscle spasms. Fexmid (Cyclobenzaprine) is recommended as an option for short course of therapy. The medical records do not clearly document the presence of muscle spasm on examination. The medical records do not demonstrate the patient presented with exacerbation unresponsive to first-line interventions. Furthermore, chronic use of muscle relaxants is not recommended by the guidelines. The request for Fexmid 7.5 mg, sixty count, is not medically necessary or appropriate.

NORCO 2.5/325MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and, Opioids for chronic pain Page(s): 74-75, 80, 124.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Opioids are recommended for chronic pain management under certain criteria. The guidelines state the following for continuation of management with Opioids; "(c) Office: 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". This case does not meet the above criteria, as the pain level and functional assessment are not addressed in the medical records. The request for Norco 2.5/325 mg, sixty count, is not medically necessary or appropriate.

1 SHOWER CHAIR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic) Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: According to the ODG, DMEs (durable medical equipment) are recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) (See ODG). Medical conditions that result in

physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature (Furthermore, shower chair is considered a comfort or hygienic equipment). The medical records provided do not indicate the patient is unable to adequately bath/shower himself currently. The request for one shower chair is not medically necessary or appropriate.

1 SPINAL CORD STIMULATOR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic) Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Spinal cord stimulators (SCS) is recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated for specific conditions such as Reflex Sympathetic Dystrophy (RSD), phantom pain, painful diabetic neuropathy or in failed back surgery syndrome with intractable radiculopathy when all conservative managements have been tried and failed following a successful trial and psychological assessment. There is little to no documentation of trial and failure of all conservative managements, such as physical therapy, spinal injections, etc. There is no documentation of a successful trial of spinal cord stimulation and psychological assessment. The request for one spinal chord stimulator is not medically necessary or appropriate.