

Case Number:	CM14-0012966		
Date Assigned:	02/24/2014	Date of Injury:	07/01/2012
Decision Date:	07/22/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/31/2014

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 Occupational 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 patient is a 34-year-old female who has filed a claim for lumbar spine musculoligamentous sprain/strain associated with an industrial injury date of July 01, 2012. A review of progress notes indicates increased low back and right shoulder pain symptoms. Findings include tenderness and hypertonicity over the paravertebral musculature, tenderness over the right sacroiliac joint, decreased lumbar range of motion, positive Fabere's test on the right, tenderness over the right shoulder region with slightly positive impingement testing, and decreased right shoulder range of motion. The treatment to date has included chiropractic therapy. Utilization review from January 16, 2014 denied the requests for Fexmid 7.5mg as the effectiveness of the first-line treatment is pending; chiropractic services 2 times a week as there is no documentation of benefits derived from previous sessions and MRI of the lumbar spine as there is no clear indication of nerve root compromise. There is modified certification for acupuncture for 3 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

VOLTAREN EXTENDED RELEASE 100 MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (nonsteroidal anti-inflammatory drugs) Page(s): 67-69.

Decision rationale: As stated on pages 67-69 of the California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. Starting this medication is a reasonable option for management of the patient's pain symptoms. Previous utilization review determination, dated January 16, 2014, has already certified this request for 1 month. Therefore, the request for Voltaren extended release 100mg is not medically necessary.

NORCO 2.5 MG -EVERY 6 TO 8 HOURS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-82.

Decision rationale: According to pages 76-78 of California MTUS Chronic Pain Medical Treatment Guidelines, a therapeutic trial of opioids is recommended in cases where non-opioid analgesics have failed, goals of therapy have been set, baseline pain and functional assessments have been made, likelihood of improvement is present, and likelihood of abuse or adverse outcome is absent. As noted on page 78-82 of the California MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There is no documentation regarding failure of non-opioid analgesics or a baseline assessment in this patient. Previous utilization review determination, dated January 16, 2014, has already certified this request for 1 month. Therefore, the request for Norco 2.5mg every 6-8 hours is not medically necessary.

ACUPUNCTURE 2 TIMES PER WEEK: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function chapter, page 114.

Decision rationale: As noted on page 114 of the California MTUS ACOEM Guidelines, they stress the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician is paramount. In addition, Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Functional improvement

should be observed within 3-6 treatments, with treatments rendered 1 to 3 times per week and an optimum duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. The body part to which these sessions are directed to is not indicated. Also, the total quantity requested is not specified. Additional information is necessary to support this request. Therefore, the request for acupuncture 2 times per week was not medically necessary.

FEXMID 7.5 MG: 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 Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines state that Cyclobenzaprine is a skeletal muscle relaxant and a CNS depressant that is recommended as a short-course therapy. The effect is greatest in the first 4 days of treatment. The requesting physician notes that this medication is prescribed in addition to the other medications in order to effectively reduce muscle spasm. However, the patient has just been started on NSAID and opioid therapy, and the efficacy of these medications has not been documented in this patient. The additional benefit to be derived from this medication is unclear at this time. Also, the requested quantity is not specified. Therefore, the request for Fexmid 7.5mg was not medically necessary.

CHIROPRACTIC SERVICES 2 TIMES PER WEEK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY/MANIPULATION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines state that the goal of manual therapy is to achieve positive symptomatic or objective measurable functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the low back, trial of 6 visits is recommended, and with evidence of objective functional improvement, a total of up to 18 visits is supported. In addition, elective/maintenance care is not medically necessary. This patient has had previous chiropractic sessions. There is no documentation describing the derived functional benefits of these sessions. The body part to which these sessions are directed to is not indicated. Also, the total quantity requested is not specified. Therefore, the request for chiropractic services 2 times per week was not medically necessary.

MRI (MAGNETIC RESONANCE IMAGE) OF THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, MRIs (magnetic resonance imaging).

Decision rationale: As stated on pages 303-304 of the ACOEM Practice Guidelines referenced by California MTUS, imaging of the lumbar spine is recommended in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise, failure to respond to treatment, and consideration for surgery. According to ODG, lumbar MRIs are recommended in patients with lumbar spine trauma with neurological deficit or seatbelt fracture; uncomplicated low back pain with suspicion of cancer or infection, with radiculopathy after one month conservative therapy or sooner if severe or progressive neurologic deficits, with prior lumbar surgery, or with cauda equina syndrome; or myelopathy -- traumatic, painful, sudden onset, stepwise progressive or slowly progressive, and infectious disease or oncology patient. In this case, there is no documentation of the abovementioned conditions in this patient. The requesting physician notes that all measures of conservative care were exhausted but failed, however, the patient has not been on pain medications in the past few months due to pregnancy, and has just been re-started on pain medications. The patient does not present with neurologic compromise accompanying the low back pain. Therefore, the request for MRI of the lumbar spine was not medically necessary.