MAXIMUS Federal Services

Case Number:	CM14-0126197		
Date Assigned:	08/20/2014	Date of Injury:	07/11/2014
Decision Date:	10/02/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/08/2014

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:

This is a 20 year old male with a 7/11/2014 date of injury. The exact mechanism of the original injury was not clearly described. A progress reported dated 7/18/14 noted subjective complaints of worsening lumbosacral pain rated at 9/10, which rates to LLE. Objective findings included lumbar tenderness, decreased ROM, and normal sensation with symmetric lower extremity DTRs. Current medications include Etodolac and Polar Frost Gel. Diagnostic Impression: lumbosacral neuritis, lumbar sprainTreatment to Date: medication managementA UR decision dated 7/30/14 denied the request for MRI of the lumbar spine. This injury is acute and there has been very little in the way of conservative treatment and there are no focal neurologic deficits. It also denied cyclobenzaprine 5 mg #30. Guidelines do not support the use of muscle relaxants in the treatment of acute musculoskeletal injuries. It also denied Polar Frost 150 mg 5 oz gel x 1 tube. Guidelines do not support the use of topical analgesics in the treatment of acute pain. It also denied heat-moist heat pad - custom touch 13 x 13. The patient was already approved for a multipurpose hot/cold therapy pack; a separate heating pad is not necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Lumbar Spine: Upheld

Claims Administrator 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) (http://www.odg-twc.com/odgtwc/low_back.htm#Radiography)

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 - MRI

Decision rationale: CA MTUS supports imaging of the lumbar spine in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration for surgery. However, there were no unequivocal objective findings that identify specific nerve compromise on the neurologic examination. Furthermore, there has not been an adequate trial of conservative therapy. Therefore, the request for MRI of the lumbar spine was not medically necessary.

Retrospective Cyclobenzaprine 5mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 41-42, 63-66.

Decision rationale: According to page 41 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. CA MTUS Chronic Pain Medical Treatment Guidelines, state that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement, and no additional benefit has been shown when muscle relaxants are used in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The patient is already on an NSAID and there is no evidence that addition of a muscle relaxant will result in additional benefit, especially with the risk of dependence. Therefore, the request for cyclobenzaprine 5 mg #30 was not medically necessary.

Retrospective Polar Frost 150mg 5 oz Gel x1 tube: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://apg-i.acoem.org/Browser/ViewRecommendation.aspx?rcm=3573&text=ICE

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee and leg chapter Other Medical Treatment Guideline or Medical Evidence: http://www.polarfrostuk.com/the-gel.ashx, http://www.mettlerelectronics.com/images/products/polarfrost/PolarFrost_ColdGel_MSDS.pdf

Decision rationale: CA MTUS does not specifically address this issue. An online search revealed that this topical medication contains alcohol, menthol, Carbomer, Triethanolamine, Propylene, Glycol, Aloe barbadensis extract, Silica, Methylparaben, Propulparaben. There are no guideline recommendations for topical agents with these components. Little has been documented regarding pain control with guideline recommended medications and treatment modalities. Therefore, the request for Polar Frost 150 mg 5 oz Gel x 1 tube was not medically necessary.

Retrospective Heat-Moist Heat Pad-Custom Touch 13x13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Additional with above, ACOEM (Chapter 8-14) and Official Disability Guidelines (ODG) Heat therapy:

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

Decision rationale: CA MTUS does not specifically address this issue. ODG states on heat/cold packs that these are recommended. Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders, though due to the relative ease and lack of adverse affects, local applications of cold packs may be applied during first few days of symptoms followed by applications of heat packs to suit patient. However, although hot/cold packs are recommended, it is noted that he has already been previously approved for a hot/cold therapy pack. It is unclear why he would need an additional heat pad. Therefore, the request for Heat-Moist heat Pad - Custom Touch 13 x 13 was not medically necessary.