

Case Number:	CM14-0128578		
Date Assigned:	08/18/2014	Date of Injury:	01/05/2010
Decision Date:	09/22/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/13/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 51 year old female who had work-related injuries on 01/05/10; the mechanism of injury was not described. Physical examination dated 02/07/14 noted there was decreased flexion/extension and bilateral bending by 10% of normal. Flexion was 60 degrees. Extension was 25 degrees. Bilateral lateral bending was 25 degrees. There was tenderness in bilateral iliolumbar ligament. There were muscle spasms and trigger points to the bilateral lumbosacral paraspinal muscles. There was decreased light touch sensation in the dorsal aspect of the bilateral feet. There were decreased bilateral ankle reflexes. There were normal reflexes in the bilateral knees. There was decreased strength with bilateral dorsiflexion and right EHL muscle. Normal strength in bilateral knee flexors and knee extensors. There was positive bilateral straight leg raise at 40 degrees. MRI of the lumbar spine on 04/16/10 shows central disc protrusion L5-S1 with positive posterior high intensity zone. No associated central canal stenosis, lateral recess, or neural foraminal narrowing. Multilevel disc degeneration, Schmorl nodes scattered throughout the lower thoracic spine and lumbar spine, without associated central canal stenosis lateral recess or neural foraminal stenosis. There was no physical examination of the shoulder in the clinical information submitted. There was a statement in the 02/21/14 note stating that the injured worker had multiple rounds of physical therapy, acupuncture, and medication. Moreover, she had tremendous success with prior left shoulder cortisone injection. Since she had a flare up of her shoulder impingement and had prior injections that gave her over six weeks relief with over 60% benefit. She was a candidate for another subacromial bursal injection. Prior utilization review on 08/08/14 was non-certified. There was no clinical documentation of the injured worker using a TENS unit or demonstrating functional improvement with muscle relaxant.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 7.5 MG #90: 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): 63.

Decision rationale: As noted on page 63 of the Chronic Pain Medical Treatment Guidelines, muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the medical necessity of this medication cannot be established at this time.

MENTHODERM GEL, 2 BOTTLES RIGHT SHOULDER, INJECTION, PER 08/01/14 FORM (3): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Page(s): 105.

Decision rationale: As noted on page 105 of the Chronic Pain Medical Treatment Guidelines, salicylate topicals are recommended in the treatment of chronic pain. This compound is known to contain menthol and methyl salicylate. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. However, there is no indication in the documentation that the injured worker cannot utilize the readily available over-the-counter version of this medication without benefit. As such, the request for this medication cannot be recommended as medically necessary.

RIGHT SHOULDER, INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

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

Decision rationale: The request for a right shoulder injection is not medically necessary. The clinical documents submitted for review does not support the request. There is no physical examination of right shoulder submitted. As such, medical necessity has not been established.

TENS UNIT REPLACEMENT PADS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation Page(s): 113-116.

Decision rationale: The request for review TENS replacement pads is not medically necessary. The clinical information submitted does not support the request. There is no documentation giving the reason, or the body part that the TENS unit is used for. Also there is no clinical evidence of functional improvement with the use of TENS. Therefore medical necessity has not been established.