

Case Number:	CM14-0020239		
Date Assigned:	04/25/2014	Date of Injury:	07/06/2012
Decision Date:	07/08/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/18/2014

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 Management 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 54 year old female who was injured on 07/06/12 when she fell approximately 12 feet through a hole in the attic and landed in a seated position. She sustained a burst fracture and underwent decompression and instrumented posterior fusion T12-L4. The injured worker also is status post C5-6 ACDF in September 2013. She participated in post-operative therapy following both surgeries. The injured worker has been diagnosed with neurogenic bladder and overactive bladder. She also has psychological issues (depression, anxiety) and has undergone psychological treatment. Per QME report dated 01/07/14, the injured worker presented with chief complaint of neck pain, back pain, and lower extremity weakness. She also has a problem with bladder control. Current medications were listed as Wellbutrin, Buspar, Naproxen, Flexeril, and estazolam. On examination motor strength was 5/5 in the upper extremities; -5/5 in the lower extremities diffusely, no nerve pattern. Sensory exam was slightly decreased pinprick in both hands and feet nonspecific non-nerve pattern. Vibratory sense was decreased in the feet. Cerebellar exam was normal. The injured worker walks with a walker. Movements of the cervical and lumbar spine were restricted. Spurling's sign was negative. Shoulder examination was negative with normal range of motion throughout the bilateral shoulders. Wrists and hands were nontender and without swelling or warmth. Range of motion was normal in all planes. Tinel's, Phalen's and Finkelstein's were negative bilaterally. Elbow and forearm exam was within normal limits. Knee and ankle exam were within normal limits. A request for neurostimulator treatment/ peripheral nerve stimulation for 4 days, physical therapy sessions x 8, follow up with neurosurgeon, Toradol 60mg injection, and Flexeril 7.5mg was non-certified per utilization review determination dated 01/21/14. The reviewer noted that the injured worker was seen by the requesting provider on 01/14/14 at which time examination revealed decreased range of motion; focal neurologic deficits were not documented. These findings were

essentially unchanged as compared to progress report dated 11/03/13. It was noted that neurostimulation may be indicated for neuropathic pain, but the most recent available subjective and objective findings were negative for neuropathic pain; therefore, neurostimulation is not appropriate. The request for physical therapy to increase range of motion of the upper extremities is not warranted as the available clinical documentation did not demonstrate deficits in upper extremity range of motion or a diagnosis involving the upper extremities. It was further noted that the injured worker had reported that prior use of physical therapy was not helpful and records reflect that function deteriorated despite the use of physical therapy. A follow-up visit with a neurosurgeon was non-certified, again noting that the injured worker's clinical findings were negative for neuropathic pain or neurologic dysfunction. Her clinical presentation remained stable and medications requiring frequent monitoring by a neurosurgeon were not being utilized. Toradol was non-certified, noting that Toradol is not warranted for minor or chronic painful conditions, and should be reserved for cases of moderately severe acute pain requiring analgesia at an opioid level. The clinical documentation was negative for indications of acute, moderately severe pain for the injured worker in this case. Finally, it was determined that Flexeril was not supported in this case as the injured worker did not have acute symptomatology/exacerbation of chronic pain, and moreover, Flexeril is not for use in combination therapy, as was recommended in this case (with Naproxen).

IMR ISSUES, DECISIONS AND RATIONALES

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

NEUROSTIMULATOR TREATMENT/ PERIPHERAL NERVE STIMULATION FOR 4 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Spinal cord stimulators (SCS).

Decision rationale: While neurostimulation/peripheral nerve stimulation may be indicated for treatment of certain forms of neuropathic pain, there is no documentation in the clinical information provided that the injured worker presents with neuropathic pain. as such, medical necessity is not established for the requested neurostimulator treatment/peripheral nerve stimulation for 4 days.

PHYSICAL THERAPY SESSIONS, #8: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: The injured worker sustained an injury when she fell from an attic to the floor approximately 10 feet below, resulting in a burst fracture and underwent decompression and instrumented posterior fusion T12-L4. The injured worker subsequently underwent C5-6 ACDF in September 2013. Both surgeries were followed by post-operative physical therapy. The request for authorization dated 01/17/14 stated that physical therapy 2 x 4 was to increase range of motion in both upper extremities. However, there was no objective evidence of diminished range of motion in either upper extremity. The objective findings reported in the requesting provider's progress notes dated 01/14/14 stated " ROM", but no range of motion measurements were reported and there was no indication as to what areas demonstrated decreased range of motion. Per QME report of 01/07/14, the injured worker's range of motion throughout the bilateral upper extremities was within normal limits. Noting that the injured worker had participated in prior physical therapy without significant improvement, and noting the lack of objective findings of significant weakness or diminished range of motion in the upper extremities, medical necessity is not established for physical therapy x 8.

FOLLOW UP WITH NEUROSURGEON: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

Decision rationale: The injured worker is status post multilevel posterior instrumented fusion of the thoracolumbar spine and ACDF C5-6. The current clinical data does not document significant neurologic deficits, post-operative complications, or other significant issues that would necessitate follow-up with a neurosurgeon. There was no evidence of motor, sensory or reflex changes indicative of persistent or progressive neurologic changes. As such, medical necessity is not established for follow-up with neurosurgeon.

TORADOL 60MG INJECTION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 74-80.

Decision rationale: The request for Toradol 60 mg IM is not supported as medically necessary. Per California Medical Treatment Utilization Schedule this medication is not indicated for minor or chronic painful conditions. The records as submitted do not indicate that the injured worker met this criteria and medical necessity was not established.

FLEXERIL 7.5MG, #90: Upheld

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

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

Decision rationale: The request for Flexeril 7.5 mg # 90 is not recommended as medically necessary. The records indicate the injured worker has chronic pain. California Medical Treatment Utilization Schedule does not support the use of muscle relaxants in the treatment/management of chronic pain. The records indicate this medication was to be used in combination therapy with an NSAID. Per California Medical Treatment Utilization Schedule there is no substantive data which indicates improved outcomes with combination therapy. As such the medical necessity has not been established for the continued use of this medication.