MAXIMUS Federal Services

Case Number:	CM14-0022832		
Date Assigned:	06/13/2014	Date of Injury:	03/16/2013
Decision Date:	07/15/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	02/24/2014

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 47-year-old male injured on 03/16/13 as a result of a fall with subsequent pain in the neck, upper back, and low back with associated numbness and weakness in the left arm and leg. The injured worker had prior history of seizures with witnessed seizure activity while on duty resulting in fall with facial and mouth trauma. Current diagnoses included brachial neuritis/radiculitis, spinal stenosis of the cervical spine, displacement of cervical intervertebral disc without myelopathy, lumbar sprain/strain, rotator cuff syndrome, bilateral cubital tunnel syndrome, dental complaints, emotional complaints, nasal fracture, and bilateral carpal tunnel syndrome with left Guyon canal. Clinical note dated 01/20/14 indicated the injured worker complained of neck pain radiating to the left upper extremity 5-6/10 increasing with driving and improved with rest and medication. The injured worker also complained of mid and low back pain, left shoulder pain, nose/facial pain, tooth pain/flaws, and headaches. Physical examination of the cervical spine revealed slightly forward head carriage, tenderness to palpation over the paraspinal musculature and trapezius muscles bilaterally with muscle guarding and spasm, axial compression test elicited localized pain, and decreased range of motion. Sensation to pin prick and light touch in the bilateral upper extremities and lower extremities was decreased in the median nerve distribution bilaterally and left S1 dermatome, motor testing of the major muscle groups of the bilateral upper extremities and lower extremities revealed grade 4/5 weakness of the left extensor hallucis longus (EHL), and reflexes were 2+ bilaterally. Electrodiagnostic studies of the bilateral upper extremities on 06/11/13 demonstrated chronic left C6 radiculopathy, moderate to severe bilateral carpal tunnel syndrome, mild to moderate bilateral cubital tunnel syndrome, mild left Guyon canal syndrome, left L5-S1 radiculopathy, and mild bilateral tarsal tunnel syndrome. The initial request for cervical spine and lumbar spine traction

once a week for four weeks, OrthoStim four units, and Fexmid 7.5mg twice daily #60 was initially non-certified on 02/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL AND LUMBAR SPINE TRACTION ONE TIME A WEEK FOR FOUR WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

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

Decision rationale: The Official Disability Guidelines (ODG) does not recommend using powered traction devices, but home-based injured worker controlled gravity traction may be a noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain. There is no indication in the documentation that the injured worker has intent to participate in other modes of evidenced-based conservative care. As such, the request for cervical and lumbar spine traction one time a week for four weeks cannot be recommended as medically necessary at this time.

ORTHOSTIM 4 UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY INTERFERENTIAL CURRENT STIMULATION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, page(s) 116 Page(s): 116.

Decision rationale: As noted on page 116 of the Chronic Pain Medical Treatment Guidelines, TENS use is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. Criteria for TENS use includes documentation of pain of at least three months duration; evidence that other appropriate pain modalities have been tried (including medication) and failed; a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial; other ongoing pain treatment should also be documented during the trial period including medication usage; and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. Moreover, a 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. The documentation

fails to meet these criteria. As such, the request for OrthoStim 4 unit cannot be recommended as medically necessary at this time.

FEXMID 7.5 MG TWO TIMES A DAY #60: Overturned

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 Muscle relaxants (For Pain) 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. Documentation indicated objective findings significant for spasm necessitating the use of muscle relaxants. As such, the medical necessity of Fexmid 7.5 mg two times a day #60 is recommended as medically necessary at this time.