

<b>Case Number:</b>	CM14-0025572		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	12/10/2013
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 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 61 year old female injured on 12/10/13 when she was struck by a vehicle that crashed through a glass window resulting in her falling backwards and striking her head against a chair. The injured worker reported no loss of consciousness; however, did report subsequent low back pain. Diagnoses include cervical/trapezial musculoligamentous sprain/strain, lumbar musculoligamentous sprain/strain, bilateral shoulder strain/tendonitis, right wrist sprain, and right ankle/foot contusion. Current complaints include low back pain, neck pain, right periscapular pain, right hand pain, head pain, and suboccipital headaches, left shoulder pain, and right ankle/middle toe pain. The clinical note dated 01/27/14 indicates the injured worker has undergone medication management, physical therapy x 18 sessions, and chiropractic therapy; in addition to diagnostic exams. The injured worker was provided prescriptions for Fexmid 7.5mg, Norco 5/325mg twice daily, and Ortho-stem trial. Additionally, physical therapy sessions x 12 were requested. The initial request for a prescription for Fexmid 7.5mg #60, Ortho-stem 4, and 12 physical therapy sessions was initially non-certified on 02/15/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 PRESCRIPTION FOR FEXMID 7.5 MG # 60 BETWEEN 1/27/2014 AND 1/27/2014:**

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 1 prescription for Fexmid 7.5 mg # 60 between 1/27/2014 and 1/27/2014 cannot be established at this time and is not medically necessary and appropriate.

**1 REQUEST FOR ORTHOSTIM 4 BETWEEN 1/27/2014 AND 3/23/2014:** Upheld

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

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

**Decision rationale:** As note on page 116 of the Chronic Pain Medical Treatment Guidelines, Orthostim use is not recommended as a primary treatment modality, but a one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. Criteria for orthostim 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 orthostim 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 unit should be submitted. The documentation failed to provide this information. As such, the request for 1 request for Orthostim 4 between 1/27/2014 and 3/23/2014 is not medically necessary and appropriate.

**12 PHYSICAL THERAPY SESSIONS BETWEEN 1/27/2014 AND 3/23/2014:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 68.

**Decision rationale:** As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend 10 visits over 8 weeks for the treatment of lumbar strain/sprain and allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. Clinical notes indicate the injured worker has completed a total of 18 prior physical therapy sessions. There is no documentation of exceptional factors that would support the need for therapy that exceeds guidelines either in duration of treatment or number of visits. Additionally, there is no indication of objective findings to indicate functional improvement as result of the physical therapy. The medical necessity of the 12 physical therapy sessions between 1/27/2014 and 3/23/2014 cannot be established at this time and is thus not medically necessary and appropriate.