MAXIMUS Federal Services

Case Number:	CM14-0028496		
Date Assigned:	06/20/2014	Date of Injury:	07/15/1996
Decision Date:	08/14/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/06/2014

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 Orthopedic Surgeon and is licensed to practice in Florida. 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 44-year-old female who reported an injury on July 15, 1996. The mechanism of injury was not provided. On April 09, 2014, the injured worker presented with neck, headache, and low back pain due to degenerative spondylosis of the lumbar spine. There is numbness of the right toes and right fingers when pain flares, and right shoulder spasms. Current medications included Percocet, Topamax, ThermaCare heat pads, Vesicare, Voltaren Gel, Robaxin, and Imitrex. Upon examination, the injured worker had swelling to the right foot for about 2 to 3 months with difficulty getting her shoes on. Prior therapy included medications and physical therapy. The diagnoses were chronic low back pain, degenerative lumbar spondylosis, myofascial pain syndrome, chronic headache pains, cervical spondylosis and pain disorder with psychological general medical condition. The provider recommended a gym membership, Percocet, ThermaCare heat pads, Vesicare, Treximet, Voltaren gel. The provider's rationale is not provided. The Request for Authorization form is not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gym Membership (12 months): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Gym Memberships.

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

Decision rationale: The request for a gym membership is not medically necessary. The Official Disability Guidelines recommend exercise as part of a dynamic rehabilitation program, but note the gym membership is not recommended as a medical prescription unless a home exercise program has not been effective and there is a need for equipment. Exercise treatment needs to be monitored and administered by medical professionals. There is no documentation of failed home exercise or if the injured workers need for specific equipment that would support the medical necessity for a gym membership. The medical documents provided lack of evidence of a complete and adequate assessment detailing current deficits to warrant a gym membership. As such, the request is not medically necessary.

Percocet (5/325mg): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (criteria for use).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The request for Percocet is not medically necessary. According to the California MTUS, the guidelines recommend the use of opioids for ongoing management of chronic low back pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence on the objective assessment of the injured worker's pain level, functional status, evaluation or risk for aberrant drug abuse behavior, and side effects. Additionally, there was lack of evidence of a complete and adequate pain assessment of the injured worker. The provider's request does not indicate the frequency or quantity of the medication in the request as submitted. As such, the request is not medically necessary.

ThermaCare Heat Pads: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, 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), Low Back, Thermacare heat pads.

Decision rationale: The request for ThermaCare is not medically necessary. The Official Disability Guidelines recommend heat therapy as an option. A number of studies show continuous low-level heat wrap therapy to be effective for treating low back pain. There is

moderate evidence that heat wrap therapy provides a small short-term reduction in pain and disability in acute and subacute low back pain, and that the addition of exercise further reduces pain and improves function. An adequate examination of the injured worker was not provided detailing current deficits to warrant the ThermaCare heat pad. Additionally, the provider's request does not indicate the site that the heat pad is intended for or the amount of heat pads being requested. As such, the request is not medically necessary.

Vesicare (5mg): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physician's Desk Reference (www.pdr.net).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation RxList, Vesicare, Online Database (www.RxList.com/vesicare).

Decision rationale: The request for Vesicare is not medically necessary. Vesicare is a drug that reduces muscle spasms of the bladder muscles and is used to treat symptoms of overactive bladder, such as incontinence, urinary frequency, and urgency. The included documentation lacks evidence of an adequate examination of the injured worker detailing current bladder deficits to include symptoms of an overactive bladder or incontinence. Additionally, the provider's request does not indicate the quantity or frequency of the Vesicare and the request as submitted as such, the request is not medically necessary.

Treximet (85/500mg): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physician's Desk Reference (www.pdr.net).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation RxList, Treximet, Online Database (www.RxList.com/Treximet).

Decision rationale: The request for Treximet is not medically necessary. Scientific based research notes Treximet contains a non-steroidal anti-inflammatory drug and a selective 5-hydroxytryptamine (5-HT) receptor subtype agenous. Treximet is indicated for acute treatment of migraine attacks in adults. The med is not intended for prophylactic therapy of migraine or for use in the management of hemiplegic or basilar migraine. Included documentation does not indicate that the injured worker has symptoms or a diagnosis that would be concurrent with the scientific based recommendation for Treximet. An adequate and complete assessment of the injured worker's current deficits and pain levels were not provided in the documentation for review. Additionally, the provider's request for Treximet does not indicate the quantity or frequency of the medication and the request as submitted as such, the request is not medically necessary.

Voltaren Gel (1%): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111.

Decision rationale: The request for Voltaren Gel is not medically necessary. The California MTUS Guidelines state topical analgesia are largely experimental in use, a few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Voltaren 1% gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. The documentation does not indicate that the injured worker has a diagnosis that would be concurrent for the guideline recommendation of Voltaren gel. Additionally, the provider's request does not indicate the site the gel is indicated for, the quantity or frequency in the request as submitted, as such, the request is not medically necessary.