MAXIMUS Federal Services

Case Number:	CM14-0035898		
Date Assigned:	07/30/2014	Date of Injury:	04/17/2007
Decision Date:	09/10/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	03/24/2014

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 Physical Medicine & Rehabilitation 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 53-year-old male who reported an injury on 04/17/2007. The mechanism of injury was not stated. Current diagnoses include cervical disc displacement without myelopathy, thoracalgia, lumbar disc protrusion, headaches, anxiety, post-traumatic insomnia, cervical myofascitis, and lumbar myofascitis. The injured worker was evaluated on 05/28/2014 with complaints of bilateral posterior neck pain, mid back pain, upper back pain, and bilateral lower back pain. Previous conservative treatment includes medication management and chiropractic therapy. The current medication regimen includes omeprazole 20 mg, hydrocodone, tizanidine 4 mg, tramadol 50 mg, Elavil 10 mg, and theramine. The physical examination revealed tenderness to palpation of the cervical region bilaterally, hypertonicity, tenderness in the lumbar region, hypertonicity in the lumbar region, positive straight leg raising on the left, positive Braggard's and Kemp's testing, hypertonicity in the thoracic spine, myofascial trigger points, and 4/5 lower extremity strength. Treatment recommendations included continuation of the current medication regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Sedating Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Non-Sedating Muscle Relaxants.

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

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Efficacy appears to diminish over time and prolonged use may lead to dependence. There is documentation of myofascial trigger points and muscle spasm upon physical examination. However, there is no evidence of this patient's current utilization of this medication. There is also no frequency listed in the current request. Guidelines do not recommend long term use of muscle relaxants. As such, the request is not medically necessary.

Sentra PM (a medical food, no quantity or strength provided): 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), Medical Foods.

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

Decision rationale: Official Disability Guidelines state Sentra PM is intended for use in management of sleep disorders associated with depression. The injured worker does not maintain a diagnosis of depression. There is also no strength, frequency, or quantity listed in the current request. As such, the request is not medically necessary.

Theramine (a medical food, no quantity or strength provided): 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), Medical Food.

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

Decision rationale: Official Disability Guidelines state theramine is not recommended. There is also no strength, frequency, or quantity listed in the request. As such, the request is not medically necessary.

Decadron (no quantity or strength provided): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.drugs.com/pro/decadron.html.

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

Decision rationale: Official Disability Guidelines state oral corticosteroids are not recommended for chronic pain. There is no data on the efficacy and safety of systemic corticosteroids, and given their serious adverse effects they should be avoided. There is also no strength, frequency, or quantity listed in the current request. As such, the request is not medically necessary.

Infrared Lamp, two times per week for three weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://bodhitreeacupuncture.com/mineral-far-infrared-heat-cupping-electro-acupuncture-herbal-therapy/.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: California MTUS ACOEM Practice Guidelines state physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, TENS therapy, PENS therapy, and biofeedback have no proven efficacy in treating acute low back symptoms. Therefore, the current request cannot be determined as medically appropriate. There was also no specific body part listed in the current request. As such, the request is not medically necessary.

Myofascial release 2 times per week for 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Massage Therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: California MTUS ACOEM Practice Guidelines state physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, TENS therapy, PENS therapy, and biofeedback have no proven efficacy in treating acute low back symptoms. Therefore, the current request cannot be determined as medically appropriate. There was also no specific body part listed in the current request. As such, the request is not medically necessary.