

Case Number:	CM14-0042570		
Date Assigned:	08/08/2014	Date of Injury:	10/26/2009
Decision Date:	11/17/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/09/2014

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 Emergency Medicine 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:

This case involves an injured worker who reported an injury on 10/26/2009. No mechanism of injury was provided for review. The patient has a diagnosis of post lumbar interbody fusion, post right knee arthroscopic knee surgery and compensatory left paraspinal chronic lumbar sprain. The report on 3/4/14 was very brief and incomplete with minimal subjective complaint description and minimal objective exam description. The patient complains of pain and instability to right knee. Exam only notes antalgic gait, tenderness to palpation at right knee, left paraspinal spasms and disuse atrophy of right leg. There is no proper justification of requested services. Notes only mentions that "consideration should be given" for Botox of back muscles and "also benefit" from the requested medications and physical therapy. There is no explanation as to why the items were requested or if any prior therapies or treatments were attempted. Progress note from 1/20/14 is hand written and not legible and no medication list was provided. It is not known if patient is taking any of the medications requested or if these are new medications. No imaging or electrodiagnostic reports were provided for review. Independent Medical Review is for acupuncture of lower back(no frequency or duration), "Ab coaster", Elliptical trainer, physical therapy to right knee and lumbar area 3/week for 6 weeks (18total), "Home care assistance", Botox injection of lumbar spine, Lyrica refill, Ambien, Zanaflex and Lidoderm patch. Prior UR on 1/29/14 and 3/25/14 recommended non-certification. Notes mention multiple request for information and attempts to contact provider with no success.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture to lower back (unspecified frequency and duration): Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: There is no frequency or duration of acupuncture requested. There is no documentation of prior attempts or response to attempt. Therefore, the request for acupuncture is not medically necessary.

Ab coaster: Upheld

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

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

Decision rationale: An "Ab Coaster" is a piece of exercise equipment. There is no section in the MTUS Chronic pain or ACOEM guideline related to this issue. As per Official Disability Guidelines (ODG), exercise equipment is not medical equipment. There is no justification by the treating provider as to why patient cannot join a gym or exercise without said equipment. "Ab Coaster" is not medically necessary.

Elliptical trainer: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Knee and Leg>, <Exercise Equipment>

Decision rationale: An Elliptical trainer is a piece of exercise equipment. There is no section in the MTUS Chronic pain or ACOEM guideline related to this issue. As per Official Disability Guidelines (ODG), exercise equipment is not medical equipment. There is no justification by the treating provider as to why patient cannot join a gym or exercise without said equipment. Elliptical trainer is not medically necessary.

Physical therapy to right knee and lumbar area 3 times a week for 6 weeks: 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: As per MTUS Chronic pain guidelines, physical therapy (PT) may be recommended under certain criteria. For patient's pain, (PT) may be beneficial in improving pain and mobility. There is no mention of home physical therapy or exercise. There is no mention of prior PT or response to PT. As per MTUS Chronic pain guidelines, it recommends fading frequency from 3 sessions per week to 1 per weeks. MTUS post-surgical guidelines also recommend a maximum of 8-10 PT sessions. There is no documentation outlining the medical necessity for 18 visits. Due to lack of documentation, this request for physical therapy is not medically necessary.

Home care assistance: 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 Home Health Services Page(s): 51.

Decision rationale: As per MTUS chronic pain guidelines, home health aide may be recommended for medical treatment in patients who are bed or home bound. However, the requesting physician has failed to provide documentation to support being home bound and in need for a home health aide. There is no documentation as to what services are needed or why assistance is needed. Therefore, the request for home care assistance is not medically necessary.

Botox Injection to lumbar spine: Upheld

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

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, Lumbar and Thoracic, Botulinum Toxin (Botox)

Decision rationale: MTUS Chronic pain and ACOEM guidelines do not adequately deal with this topic. As per Official Disability Guidelines (ODG), botulinum toxin is reserved only for patients with low back pain that is refractory or failed other invasive treatments. Results are poor and transient. The lack of documentation provided does not support Botox injection as well as the patient does not meet any of these criteria. Therefore, the request for Botox injection of lumbar spine is not medically necessary.

Lyrica refill: 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 Antiepilepsy Drugs (AEDs) Page(s): 16-20.

Decision rationale: As per MTUS Chronic pain guidelines, antiepilepsy drugs (AEDs) may be useful in neuropathic pain but data is limited. Lyrica is FDA approved for diabetic neuropathy and postherpetic neuralgia only. There are no good studies to support its use in radicular pains. In this case, there is no appropriate documentation to support any neuropathy and an incomplete prescription. There is no dosage or number of tablets requested. Therefore, this request is not medically necessary.

Ambien: Upheld

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

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

Decision rationale: There are no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Ambien is a benzodiazepine agonist approved for insomnia. As per Official Disability Guidelines (ODG), it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. There is no rationale for this medication and this is an incomplete prescription with no dosage or number of tablets requested. Therefore, this request for Ambien is not medically necessary.

Zanaflex: 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 Antispasticity/antispasmodics Page(s): 60.

Decision rationale: Zanaflex (Tizanidine) is an antispasmodic muscle relaxant. It is FDA approved for muscle spasms. As per MTUS guidelines, muscle relaxants should be used for short term use and for flare-ups only. There is documentation of muscle spasms; however, there is no documentation on record as to whether Zanaflex is a new medication or chronic. This is also an incomplete prescription with no dosage or number of tabs requested. Therefore, the request for Tizanidine is not medically necessary.

Lidoderm patch: 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
Lidoderm(lidocaine patch) Page(s): 56-57.

Decision rationale: As per MTUS chronic pain guidelines, Lidoderm is only approved for peripheral neuropathic pain, specifically post-herpetic neuralgia. There is little evidence to support its use in other neuropathic pain conditions. The patient does not have a diagnosis that supports use of Lidoderm and physical exam does not support any signs of neuropathic pain. This is also an incomplete prescription with no dosage or number of tabs requested. Therefore, the request for Lidoderm patches is not medically necessary.