

Case Number:	CM15-0001836		
Date Assigned:	01/12/2015	Date of Injury:	04/18/2013
Decision Date:	03/13/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	01/06/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 50-year-old male who reported an injury on 04/18/2013. The mechanism of injury was reportedly when he was moving/lifting a metal cage. His diagnoses include umbilical hernia, low back pain, lumbar spine sprain/strain, radiculitis to the lower extremities, bilateral knee pain, bilateral knee internal derangement, anxiety disorder, mood disorder, and stress. Past treatments were noted to include medications. On 11/06/2014, it was noted the injured worker had pain that he rated 6-7/10 to his umbilical region, 8/10 to his low back, and 6/10 to 7/10 to his bilateral knees. Upon physical examination, it was noted the injured worker had an umbilical hernia. It was also indicated that the injured worker had tenderness to palpation to the lumbar spine and decreased range of motion to his lumbar spine that measured flexion to patella, extension was 15 degrees, left lateral flexion was 20 degrees, right lateral flexion measured 10 degrees, left rotation measured 15 degrees, and right rotation measured 35 degrees. It is noted he had tenderness to palpation over the medial and lateral joint lines bilaterally and decreased range of motion to his bilateral knees measuring right flexion at 105 degrees, right extension measured -10 degrees, left flexion measured 125 degrees, and left extension measured -10 degrees. It was indicated he had positive McMurray's and Lachman's bilaterally. He had slightly decreased sensation to the L4, L5, and S1 dermatomal distributions bilaterally and decreased motor strength to the bilateral extremities. His medications were noted to include Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, capsaicin, flurbiprofen, menthol, cyclobenzaprine, and Gabapentin. His treatment plan was noted to include aquatic therapy, injections, and orthopedic surgeon referral. A request was received for Ultram ER (tramadol)

150 mg #30, (cyclobenzaprine) 7.5 mg #60, aqua therapy 3 times a week for 4 weeks (12 visits), home interferential unit, and LSO brace. The Request for Authorization was signed 11/24/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram ER (tramadol) 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Page(s): 76-78, 93-94.

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

Decision rationale: The request for Ultram ER (tramadol) 150mg #30 is not medically necessary. According to the California MTUS Guidelines, ongoing use of opioids must be monitored with the direction of the 4 A's. The 4 A's for ongoing monitoring include analgesia, activities of daily living (ADLs), adverse side effects, and aberrant drug taking behaviors. The clinical documentation submitted for review did not indicate the injured worker's pain in ADLs with and without the use of this medication, and a urine drug screen was not provided to determine medication compliance. Consequently, the request is not supported by the evidence based guidelines. Additionally, the request does not specify duration and frequency of use. As such, the request for Ultram ER (tramadol) 150mg #30 is not medically necessary.

Fexmid(Cyclobenzaprine) 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

Decision rationale: The request for Fexmid(Cyclobenzaprine) 7.5mg #60 is not medically necessary. According to the California MTUS Guidelines, Fexmid is a muscle relaxant that is not to exceed 3 weeks of use. The clinical documentation submitted for review did not indicate how long this injured worker had been on this medication, and it was also not indicated how this medication improved function. Consequently, the request is not supported. Additionally, the request does not specify duration and frequency of use. As such, the request for Fexmid(Cyclobenzaprine)7.5mg #60 is not medically necessary.

Aqua therapy 3x a week for 4 weeks (12 visits): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 99. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

Decision rationale: The request for Aqua therapy 3x a week for 4 weeks (12 visits) is not medically necessary. According to the California MTUS Guidelines, aquatic therapy is an alternative to land based therapy that is recommended for those with nonweight bearing status such as extreme obesity. The guidelines under physical medicine indicate that no more than 10 visits should be medically necessary unless exceptional factors are notated. The clinical documentation submitted for review indicated the injured worker had decreased range of motion to his lumbar spine and bilateral knees; however, it was not indicated that this injured worker was non weight bearing. Additionally, the request exceeds the guidelines recommended duration of treatment, and exceptional factors were not indicated. Consequently, the request is not supported. Furthermore, the request does not specify which body region this is to benefit. As such, the request for Aqua therapy 3x a week for 4 weeks (12 visits) is not medically necessary.

Home Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

Decision rationale: The request for Home Interferential Unit is not medically necessary. According to the California MTUS Guidelines, interferential current stimulation (ICSM) is not recommended as an isolated intervention. The clinical documentation submitted for review indicated the injured worker had decreased range of motion to his lumbar spine and bilateral knees; however, it was not indicated that the injured worker was performing an adjunctive therapeutic exercise program. Additionally, the request does not specify which body region this is to benefit. Consequently, the request is not supported. As such, the request for Home Interferential Unit is not medically necessary.

LSO brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: A request was received for LSO brace. According to the California MTUS/ACOEM Guidelines, lumbar supports have not been shown to have lasting benefit during chronic pain. The clinical documentation submitted for review did not indicate a rationale for the requested service, and the injured worker is in the chronic phase. Consequently, the request is not supported by the evidence based guidelines. As such, the request for LSO brace is not medically necessary.

