

Case Number:	CM15-0181732		
Date Assigned:	09/23/2015	Date of Injury:	06/11/2015
Decision Date:	11/16/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/15/2015

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

Certification(s)/Specialty: Emergency Medicine

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 is a 57-year-old male worker with a date of injury 6-11-2015. The medical records indicated the injured worker (IW) was treated for cervical spine musculoligamentous sprain and strain with bilateral upper extremity radiculitis; thoracic musculoligamentous sprain and strain; and lumbar musculoligamentous sprain and strain with bilateral lower extremity radiculitis. In the 8-7-15 notes, the IW reported neck pain radiating to the bilateral upper extremities and mid and low back pain radiating to the bilateral lower extremities. Objective findings on 8-7-15 included tenderness and spasm over the cervical, thoracic and lumbar bilateral paraspinal musculature, the L4-L5 spinous process, lumbosacral junction, right sacroiliac joint and bilateral trapezius muscle. Axial compression elicited localized pain. Range of motion (ROM) of the cervical spine measured 37 degrees flexion, 44 degrees extension, 63 degrees right rotation, 60 degrees left rotation, 34 degrees right lateral flexion and 32 degrees left lateral flexion. Thoracic ROM was 48 degrees flexion, 27 degrees right rotation, and 35 degrees left rotation. Lumbar ROM was 43 degrees flexion, 14 degrees extension, 16 degrees right side bending and 14 degrees left side bending. Straight leg raising radiated pain into the bilateral calves. Sacroiliac stress test was positive on the right. Sensation was decreased in the right C6 and C7 dermatomes and the right L4 through S1 dermatomes. Motor testing of the major muscle groups in the upper and lower extremities showed Grade 4 out of 5 weakness of the extensor hallucis longus, bilaterally. Biceps, triceps, brachioradialis, patellar and Achilles reflexes were 2+ bilaterally. Treatments included previous physical therapy. A urine drug screen on 8-7-15 was negative for all drugs. The IW was temporarily totally disabled. The treatment plan was for chiropractic therapy, home

interferential unit, medications for pain and spasm and MRI scans. A Request for Authorization dated 8-7-15 was received for Fexmid 7.5mg, #60, Tylenol #3, #60, chiropractic treatment three times a week for four weeks for the cervical, thoracic and lumbar spine, home interferential unit, MRI of the lumbar spine and MRI of the cervical spine. The Utilization Review on 8-21-15 non-certified the request for Fexmid 7.5mg, #60 and Tylenol #3, #60, modified the request for chiropractic treatment three times a week for four weeks for the cervical, thoracic and lumbar spine to allow sessions three times a week for two weeks; and non-certified the request for home interferential unit, MRI of the lumbar spine and MRI of the cervical spine; CA MTUS and ACOEM guideline criteria for these treatments were not met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fexmid 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate documentation of a recent acute exacerbation and poor effectiveness for chronic long-term use, the request is not medically necessary.

Tylenol #3 qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement seen. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome. As such, the request is not medically necessary.

Chiropractic treatment 3 times a week for 4 weeks, cervical, thoracic, lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. The guidelines state the following: Low back: Recommended as an option. Therapeutic care Trial of 6 visits over weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care not medically necessary, Recurrences/flare-ups need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. In this case, the patient does not qualify for the number of requested physical therapy sessions as indicated above. An initial trial of 6 visits with continued treatments with evidence of objective functional improvement. As such, the request is not medically necessary.

Home Interferential (IF) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Interferential current therapy (IFC).

Decision rationale: The request is for the use of Interferential current therapy (IFC). The MTUS guidelines are silent regarding this issue. The ODG guidelines state the following: Under study for osteoarthritis and recovery post knee surgery; not recommended for chronic pain or low back problems. After knee surgery, home interferential current therapy (IFC) may help reduce

pain, pain medication taken, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. (Jarit, 2003) See also the Pain Chapter. A recent industry-sponsored study concluded that interferential current therapy plus patterned muscle stimulation (using the RS-4i Stimulator) has the potential to be a more effective treatment modality than conventional low-current TENS for osteoarthritis of the knee. (Burch, 2008) In this case the patient does not qualify for the use of this product as it is not advised for any condition including low back pathology. It is under study for the recovery post knee surgery. It is not advised for chronic pain. As such, the request is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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 & Thoracic (Acute & Chronic)/ MRIs (magnetic resonance imaging).

Decision rationale: The request is for an MRI of the lumbar spine. The ODG guidelines state the following regarding qualifying criteria: Indications for imaging - Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit; Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit); Uncomplicated low back pain, suspicion of cancer, infection, other red flags; Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Uncomplicated low back pain, prior lumbar surgery; Uncomplicated low back pain, cauda equina syndrome; Myelopathy (neurological deficit related to the spinal cord), traumatic; Myelopathy, painful- Myelopathy, sudden onset- Myelopathy, stepwise progressive; Myelopathy, slowly progressive; Myelopathy, infectious disease patient; Myelopathy, oncology patient- Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation) In this case, the patient would not qualify for an MRI based on the above set standards. This is secondary to a lack of a change in clinical status or described red flags. There is a lack of documentation of persistent pain and radiculopathy after conservative therapy, which includes physical therapy. As such, the request is not medically necessary.

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back complaints/MRI.

Decision rationale: The request is for an MRI. The ACOEM guidelines state that when there is physiological evidence of tissue insult or neurological deficits, consider a discussion with a

consultant regarding the next steps including MRI imaging. An imaging study may be appropriate in patients where symptoms have lasted greater than 4-6 weeks and surgery is being considered for a specific anatomic defect or to further evaluate the possibility of serious pathology, such as a tumor. Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. The ODG guidelines regarding qualifying factors for an MRI of the neck or upper back are as follows: Indications for imaging - MRI (magnetic resonance imaging): Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present; Neck pain with radiculopathy if severe or progressive neurologic deficit; Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present; Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present; Chronic neck pain, radiographs show bone or disc margin destruction- Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal". Known cervical spine trauma: equivocal or positive plain films with neurological deficit- Upper back/thoracic spine trauma with neurological deficit. In this case, the records do not indicate new red flags which would warrant further imaging evaluation. The x-rays were reported to be non-diagnostic. Also, there has not been a trial of physical therapy and re-evaluation prior to further imaging. As such, the request is not medically necessary.