

Case Number:	CM15-0182052		
Date Assigned:	09/23/2015	Date of Injury:	08/08/2007
Decision Date:	10/27/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	09/16/2015

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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

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 62 year old female, who sustained an industrial injury on 8-08-2007. The injured worker is being treated for trigger points in the bilateral levator scapulae and rhomboids, bilateral sacroiliitis right greater than left, facet arthropathy at L5-S1 bilaterally, disc herniation L4-5 and L5-S1, chronic neck pain, chronic low back pain, chronic pain syndrome, and cervicogenic headaches. Treatment to date has included surgical intervention (interlaminar laminotomy at T12-L1 (10-01-2014), anterior cervical decompression and fusion C4-5, C5-6 and C6-7, posterior spinal fusion L3-4, right hip surgery and right knee surgery), physical therapy, medications and home exercise. Per the Primary Treating Physician's Progress Report dated 7-08-2015, the injured worker reported constant neck pain rated 8 out of 10 with radiation to the bilateral shoulders all the way down the bilateral upper extremities. She also reports constant low back pain rated 9 out of 10 with radiation to the bilateral lower extremities down to the feet. Her current medications include Gabapentin, Robaxin, Oxycodone, and Fioricet, which provide her 50% symptomatic relief and help increase her activities of daily living. She reports that her neck pain and low back pain feel worse since the last visit. Objective findings included tenderness to palpation with restricted ranges of motion in all planes of the cervical spine. Per the medical record dated 6-04-2015 she reported constant neck pain rated as 7 out of 10 and constant low back pain rated as 9 out of 10. The plan of care on 7-08-2015 included, and authorization was requested for Fiorinal #30, cold and-or heat therapy and TENS unit. On 8-12-2015, Utilization Review non-certified/modified the request for Fiorinal #30, cold and-or heat therapy and TENS unit citing lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fiorinal one tablet q6h PRN for headaches #30: 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): Barbiturate-containing analgesic agents.

Decision rationale: Fiorinal one tablet q 6h prn for headaches #30 is not medically necessary. Fiorinal is Fioricet a Barbiturate-containing analgesic agent (BCAs). According to CA MTUS page 23 Barbiturate-containing analgesic agents (BCAs) is not recommended for chronic pain. The potential for drug dependence is high and no evidence exist to show a clinically important enhancement of analgesic efficacy of BCAs due to the Barbiturate constituents. There is also a risk of medication overuse as well as rebound headache. The claimant is also on an Opioid and Benzodiazepine which also has a high risk of drug dependence. Additionally, the claimant does not have a history or medical condition which requires this medication for acute or long term use; therefore the requested medication is not medically necessary.

Cold and/or therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation.

Decision rationale: The American College of Environmental Medicine states that applications of heat and cold are recommended as method of symptom control for ankle and foot complaints. Additionally, at home applications of cold during first few days of acute complaint are recommended; thereafter, application of heat or cold as patient prefers, unless swelling persists then use cold. The ACOEM supports simple low-tech applications of heat and cold as opposed to the motorized cold therapy device being proposed. Finally, the claimant's condition is chronic. The ACOEM supports this therapy for acute conditions; therefore, the requested therapy is not medically necessary.

TENS unit: 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): Transcutaneous electrotherapy.

Decision rationale: TENS is not medically necessary. Page 114 of MTUS states that a one month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to an evidence based functional restoration program. As it relates to this case TENS unit was recommended as solo therapy and not combined with an extensive functional restoration program. Per MTUS TENS unit is not medically necessary as solo therapy.