

Case Number:	CM15-0195892		
Date Assigned:	10/09/2015	Date of Injury:	07/06/2015
Decision Date:	11/18/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/06/2015

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: New York

Certification(s)/Specialty: Anesthesiology

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 52 year old female, who sustained an industrial injury on 7-6-2015. The injured worker is undergoing treatment for: bilateral elbows, bilateral shoulder, low back, bilateral wrists and hands, mid back and neck. On 8-21-15, he reported pain to the bilateral elbows, bilateral shoulder, low back, bilateral wrists and hands, mid back and neck. His pain is not described or rated. Objective findings revealed tenderness with spasm and muscle guarding in the neck and trapezius, decreased cervical spine range of motion, tenderness with spasm and guarding and decreased range of motion of the thoracic spine, tenderness with spasm, guarding, decreased range of motion of the lumbar spine and positive straight leg raise testing on the right. The bilateral shoulders were noted to have tenderness, positive impingement, positive cross arm test, and decreased range of motion; bilateral elbows were noted to have tenderness, positive cozen's test bilaterally, decreased range of motion and positive reverse cozen's bilaterally. The bilateral wrists had tenderness, positive tinels testing bilaterally and decreased range of motion. The treatment and diagnostic testing to date has included: medications, and x-rays are reported to have been taken (8-21-15), there is no discussion of which body parts x-rays were taken of, or the results of the radiographs. There are no other treatment or diagnostic tests documented. Medications have included: Norco, Voltaren XR, and Fexmid. The records are unclear regarding when each of these medications were originally prescribed. There is no discussion regarding the efficacy of these medications. Current work status: temporarily totally disabled for 4-6 weeks. The request for authorization is for: Norco 5mg quantity 30, Voltaren XR 100mg quantity 30, and urinary drug screen quantity 1, physical therapy for the cervical, thoracic and lumbar spine

quantity 12; physical therapy for the bilateral shoulders, elbows and wrists quantity 12; interferential unit (infinite use); Fexmid 7.5mg. The UR dated 9-28-2015: certified the request for Norco 5mg quantity 30, Voltaren XR 100mg quantity 30, and urinary drug screen quantity 1; modified certification of physical therapy for the cervical, thoracic, and lumbar spine quantity 6, physical therapy for the bilateral shoulders, elbows and wrists quantity 6; and non-certified interferential unit (infinite use) and Fexmid 7.5mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x12, for the cervical, thoracic and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. The requested number of sessions of physical therapy exceeds the guideline recommendations. Medical necessity for the requested physical therapy x 12 for the cervical, thoracic and lumbar spine is not established. The requested physical therapy sessions are not medically necessary.

Physical therapy x12, for the bilateral shoulders, elbows and wrists: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy and Other Medical Treatment Guidelines Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed

after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. The requested number of sessions of physical therapy exceeds the guideline recommendations. Medical necessity for the requested physical therapy x 12 for the bilateral shoulders, elbows and wrists is not established. The requested physical therapy sessions are not medically necessary.

Interferential (IF) unit (infinite use) x1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Interferential Therapy.

Decision rationale: According to MTUS, Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. This therapy is possibly appropriate for: pain ineffectively controlled due to diminished effectiveness of medications, significant pain from post-operative conditions limiting the ability to perform exercise programs, physical therapy (PT), or unresponsive to conservative treatment. The process involves paired electrodes of two independent circuits carrying differing medium frequency alternating currents so that current flowing between each pair intersects at the underlying target. ICS works in a similar fashion as TENS, but at a substantially higher frequency (4000-4200 Hz). In this case, there was no documentation of a decrease in subjective complaints, improvement in physical examination findings, an increase in functional abilities with the use of ICS. There is no indication for continued use. The requested unit is not indicated at this time. Medical necessity for the requested unit has not been established. The requested unit is not medically necessary.

Fexmid 7.5mg, #60: Upheld

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

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

Decision rationale: Fexmid (Cyclobenzaprine) is a skeletal muscle relaxant and a central nervous system (CNS) depressant. It is closely related to the tricyclic antidepressants. According to the reviewed literature, Fexmid is not recommended for the long-term treatment of chronic pain. The medication has its greatest effect in the first four days of treatment and it is not recommended for longer than 2-3 weeks. According to the CA MTUS Guidelines, muscle

relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the available records show that the patient has not shown a documented benefit or any functional improvement from prior Fexmid use. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.