

Case Number:	CM15-0022113		
Date Assigned:	02/11/2015	Date of Injury:	01/04/2013
Decision Date:	04/06/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	02/05/2015

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: 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 50 year old male who sustained an industrial injury on 1/4/13 that occurred while he was pushing 100 pound refrigerator up stairs, slipping on water, twisting and falling, landing on his buttocks. He currently complains of constant low back pain radiating down the right lower extremity with numbness. The pain intensity is 8/10. He also experiences insomnia associated with the ongoing pain. His activities of daily living are limited. Medications include cyclobenzaprine, naproxen, omeprazole, gabapentin, hydro-ap-morrh, oxycodone, ramiprimitil, Soma. His laboratory evaluations regarding prescription medications were consistent with current medications. Diagnoses include persistent/ recurrent right inguinal hernia, bilateral inguinal hernia repair with recurrence; low back pain syndrome; lumbar facet arthropathy; lumbar radiculitis. Treatments include physical therapy with limited benefit, acupuncture helpful, medications with limited benefit and lumbar epidural steroid injections with limited benefit. Diagnostics include abnormal MRI of the lumbar spine (4/21/14). On 1/6/15 Utilization Review non-certified the requests for Anaprox DS 550 mg # 60; Fexmid 7.5 mg # 60; bilateral upper extremity electromyography and nerve conduction studies; bilateral elbow diagnostic ultrasound citing MTUS: Chronic Pain Medical treatment Guidelines: Non-steroidal Anti-inflammatories; MTUS: Chronic Pain medical treatment Guidelines: Cyclobenzapripines; ODG: Ultrasound respectively.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox DS 550 mg # 60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications non-steroidal anti-inflammatory drugs Page(s): 22, 67-68.

Decision rationale: According to the 12/15/2014 hand written report, this patient presents with low back pain that radiates to the right knee with numbness. The current request is for Anaprox DS 550 mg # 60. The request for authorization is on 12/15/2014. The patient's work status is "temporarily Totally Disabled until 5-6 week." The MTUS Guidelines page 22 reveal the following regarding NSAID's, "Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted." In reviewing the provided reports, Anaprox DS first noted in the 09/24/2014 report; it is unknown exactly when the patient initially started taking this medication. The treating physician indicates that the patient's pain without medication is a 7/10 and with medication pain is a 4/10. In this case, given that the patient has chronic pain and the treating physician documented the efficacy of the medication as required by the MTUS guidelines. The request IS medically necessary.

Fexmid 7.5 mg # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: According to the 12/15/2014 hand written report, this patient presents with low back pain that radiates to the right knee with numbness. The current request is for Fexmid 7.5 mg # 60. For muscle relaxants for pain, the MTUS Guidelines page 63 state "Recommended non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they showed no benefit beyond NSAIDs and pain and overall improvement." A short course of muscle relaxant may be warranted for patient's reduction of pain and muscle spasm. Review of the available records indicate that this medication is been prescribed longer then the recommended 2-3 weeks. The treating physician is requesting Fexmid #60 and it is unknown exactly when the patient initially started taking this medication. Fexmid is not recommended for long term use. The treater does not mention that this is for a short-term use to address a flare-up or an exacerbation. Therefore, the current request IS NOT medically necessary.

Bilateral upper extremities EMG/NCV: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

Decision rationale: According to the 12/15/2014 hand written report, this patient presents with low back pain that radiates to the right knee with numbness. The current request is for bilateral upper extremities EMG/NCV. The Utilization Review denial letter states "the request cannot be approved as there is no clear differential diagnosis that provides a rationale that shows that a full arm EMG and a full arm NCV are medically necessary." Regarding electrodiagnostic studies, the ACOEM supports it for upper extremities to differentiate CTS vs. radiculopathy and other conditions. Review of the provided reports does not show evidence of prior EMG/NCV of the upper extremity. In this case, the patient presents with numbness and radiating sensation in the lower extremity. The reports provided for review do not include any discussion or examinations finding of the upper extremity. The treating physician has does not provide documentation for the requested bilateral upper extremities EMG/NCV. Therefore, the current request IS NOT medically necessary.

Bilateral elbow DX ultrasound: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diagnostic Ultrasound.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Elbow chapter: Ultrasound, diagnostic.

Decision rationale: According to the 12/15/2014 hand written report, this patient presents with low back pain that radiates to the right knee with numbness. The current request is for bilateral elbow DX ultrasound. The MTUS and ACOEM guidelines do not discuss ultrasound. However ODG, knee chapter under Ultrasound, diagnostic states recommended for chronic elbow pain with the suspect of nerve entrapment or mass and suspect of biceps tendon tear and/or bursitis. In reviewing the medical reports provided, the treating physician does not indicate that the patient has chronic elbow pain with the suspicion of tendon tear and/or bursitis or nerve entrapment to warrant the use of the diagnostic ultrasound. Therefore, this request IS NOT medically necessary.