

<b>Case Number:</b>	CM15-0047223		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	10/22/2014
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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: Texas, Florida, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 52 year old male who sustained an industrial injury on 10/22/14 in a motor vehicle accident resulting in lower back pain. The initial diagnosis was low back strain and he received Flexeril and ibuprofen. Currently he complains of ongoing, constant neck pain that radiates down to his shoulders with a pain intensity of 5/10; constant mid-back, low back, left foot, tailbone and buttocks pain. The low back pain radiates down to his left lower extremity and is associated with numbness, tingling and weakness in his left leg and foot. His pain intensity is 7-9/10. His activities of daily living are limited. He is experiencing sleep difficulties. Current medications include Flexeril, Norco, and ibuprofen. Medications do offer relief of pain. Diagnosis is lumbar spine strain/ sprain; lumbar myospasm; lumbar radiculopathy; cervical facet syndrome; cervical pain. Treatments to date include medications, activity modification, physical therapy, heat and lying down which offer relief of pain, chiropractic treatments did not give any significant relief. Diagnostics include x-rays of the lumbar spine (10/30/14) reporting stable disc degeneration; lumbar MRI (1/15); electromyography/ nerve conduction study (2/4/15) abnormal; MRI of the cervical spine (3/10/15) abnormal. In the progress note dated 2/26/15 the treating provider notes no significant relief in low back pain from chiropractic treatments and recommended low back brace for support with activity, hot and cold wrap, Norco for moderate to severe pain, Flexeril for spasms, Protonix for upset stomach, interferential muscle stimulating unit and conductive garment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF or Muscle Stimulator Unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Section under NMES and Interferential.

**Decision rationale:** The evidence-based synopsis in the Official Disability Duration guidelines does not give Neuromuscular Electrical Stimulation devices a recommended rating. They instead cite: "Under study. The scientific evidence related to electromyography (EMG) triggered electrical stimulation therapy continues to evolve, and this therapy appears to be useful in a supervised physical therapy setting to rehabilitate atrophied upper extremity muscles following stroke and as part of a comprehensive PT program." Given the evidence-based guidance, the use of the device might be appropriate in a supervised physical therapy setting for post-stroke rehabilitation, but not as a purchase in a home use setting for a musculoskeletal injury. Further, regarding interferential stimulators for the low back, the ODG notes: Not generally recommended. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. Interferential current works in a similar fashion as TENS, but at a substantially higher frequency (4000-4200 Hz). See the Pain Chapter for more information and references. See also sympathetic therapy. In this case, the stimulator is not generally recommended due to negative efficacy studies, and the claimant does not have conditions for which electrical stimulation therapies might be beneficial. The request is appropriately non-certified. For the above reasons, the request is appropriately non-certified. The request is not medically necessary.

**Conductive Garment: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Section under NMES and Interferential.

**Decision rationale:** As shared in the question above, the evidence-based synopsis in the Official Disability Duration guidelines do not give Neuromuscular Electrical Stimulation devices or Interferential units a recommended rating for this claimant's clinical circumstances. The primary unit request non-certification was confirmed. As the unit was denied, there would likewise be no need for the accompanying wrap; therefore, the request is not medically necessary.

**Holt and Cold Wrap: 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) Treatment in Workers' Comp 2012.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48 of ACOEM.

**Decision rationale:** This durable medical equipment item is a device to administer regulated heat and cold. However, the MTUS/ACOEM guides note that during the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise. They are most effective when the patient uses them at home several times a day. More elaborate equipment than simple hot and cold packs are simply not needed to administer heat and cold modalities; the guides note it is something a claimant can do at home with simple home hot and cold packs made at home, without the need for such equipment. As such, this DME would be superfluous and not necessary, and not in accordance with MTUS/ACOEM. The request was appropriately non-certified.

**Norco (Hydrocodone/APAP) 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 88.

**Decision rationale:** In regards to the long term use of opiates, the MTUS poses several analytical questions such as has the diagnosis changed, what other medications is the patient taking, are they effective, producing side effects, what treatments have been attempted since the use of opioids, and what is the documentation of pain and functional improvement and compare to baseline. These are important issues, and they have not been addressed in this case. There especially is no documentation of functional improvement with the regimen. The request for long-term opiate usage is not certified per MTUS guideline review. Not medically necessary and appropriate.

**Flexeril 7.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS 8 C.C.R. 9792.20 9792.26 MTUS (Effective July 18, 2009) Page(s): 41-42 of 127..

**Decision rationale:** The MTUS recommends Flexeril (cyclobenzaprine) for a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. The addition of cyclobenzaprine to other agents is not

recommended. In this case, there has been no objective functional improvement noted in the long-term use of Flexeril in this claimant. Long term use is not supported. Also, it is being used with other agents, which also is not clinically supported in the MTUS. Is not medically necessary and appropriate.

**Protonix 20mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** The MTUS speaks to the use of Proton Pump Inhibitors like in this case in the context of Non Steroid Anti-inflammatory Prescription. It notes that clinicians should weigh the indications for NSAIDs against gastrointestinal risk factors such as: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Sufficient gastrointestinal risks are not noted in these records. The request is appropriately non-certified based on MTUS guideline review.

**Lumbar Back Support: 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) Treatment in Workers' Comp 2012.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

**Decision rationale:** The California MTUS, specifically Chapter 12 of ACOEM dealing with the low back, note on page 298. Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. This patient has had the injury for several years; per MTUS the brace would no longer be effective, and so was appropriately non-certified. Is not medically necessary and appropriate.

**Back Support Insert: 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

**Decision rationale:** Please see the response for the back brace itself above. The California MTUS, specifically Chapter 12 of ACOEM dealing with the low back, note on page 298. Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of

Symptom relief. This patient has had the injury for several years; per MTUS the brace would no longer be effective, and so was appropriately non-certified. As the brace itself was non-certified, the insert for such a brace would be unnecessary, and so would also be non-certified.