

Case Number:	CM15-0053425		
Date Assigned:	03/26/2015	Date of Injury:	11/24/2014
Decision Date:	05/15/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/20/2015

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: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 45-year-old male who reported an injury on 11/17/2014. The mechanism of injury involved a fall, the current diagnoses include a lumbosacral musculoligamentous strain, rule out lumbosacral discogenic disease, chest wall contusion, rule out right rib fracture, right shoulder sprain, right shoulder tendinitis, and shortness of breath. The injured worker presented on 01/28/2015 for an evaluation. The injured worker reported low back pain, right shoulder pain, right arm pain, chest pain, right rib pain and trouble breathing. Upon examination there was tenderness to palpation at the right sternocostal junction, lumbar spine tenderness, bilateral paraspinal muscle tenderness, bilateral sacroiliac joint tenderness, sciatic notch tenderness, gluteal muscle tenderness, palpable muscle spasm, decreased lumbar range of motion, positive straight leg raise on the right and 45 degrees right shoulder tenderness, positive Neer and Hawkins sign, right elbow tenderness, positive Cozen's and Mill's, positive Tinel's sign at the right elbow, diminished deep tendon reflexes in the bilateral upper extremities, and 4/5 motor weakness in the bilateral upper and right lower extremity. Recommendations at that time included prescriptions for tramadol 50 mg, cyclobenzaprine 7.5 mg, a compounded cream, a lumbosacral brace, an interferential unit, and a hot/cold unit. A physical therapy evaluation for the mid/upper back, lower back and right shoulder was also recommended with a frequency of 2 times per week for a duration of 6 weeks. A Request for Authorization form was then submitted on 01/28/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 x 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: The California MTUS Guidelines state 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. In this case, there was no specific body part listed in the current request. Therefore, the request is not medically necessary at this time.

Interferential Unit/Hot and cold purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: The California MTUS Guidelines state that interferential current stimulation is not recommended as an isolated intervention. There should be documentation that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse or significant pain from postoperative conditions. There is no documentation of a failure of first line conservative management prior to the request for an interferential unit. There is no mention of a contraindication to at home local applications of hot and cold packs as opposed to a motorized mechanical device. Given the above, the request is not medically necessary.

Lumbosacral brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Harris, J. Occupational medicine practice guidelines, 2nd edition (2004) - page 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 300.

Decision rationale: California MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. There was documentation of spinal instability upon examination. The medical necessity has not been established. Therefore, the request is not medically necessary.

Flurbi cream: Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5%, 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. The request for compounded cream containing flurbiprofen would not be supported. Lidocaine is not recommended in the form of a cream, lotion, or a gel. There is also no frequency listed in the request. As such, the request is not medically necessary.

Fexmid 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41, 64.

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

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as a non-sedating second line option for short-term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. In this case, it is noted that the injured worker had palpable muscle spasm upon examination. However, the request as submitted failed to indicate a specific frequency. Given the above, the request is not medically necessary.

Tramadol 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram; Ultram ER; generic available in immediate release tablet) Page(s): 78, 93-94, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review in documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, there was no documentation of a failure of non-opioid analgesics. There is no evidence of a written consent or agreement for chronic use of an opioid. There is

also no frequency listed within the request. Given the above, the request is not medically necessary.