

Case Number:	CM15-0053647		
Date Assigned:	04/16/2015	Date of Injury:	06/16/2013
Decision Date:	06/09/2015	UR Denial Date:	03/13/2015
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, Arizona

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 a 47 year old female, who sustained an industrial injury on 6/16/13. The mechanism of injury was a slip and fall. She reported neck pain and back pain. The injured worker was diagnosed with discogenic lumbar condition with a MRI of the neck showing disc disease a C2-5 and C6-7, protrusions and a discogenic lumbar condition with facet inflammation. A MRI showed disc disease at L3-4 with protrusion, spondylosis at L4-5 and protrusion at L5-S1. Other diagnoses included post-concussion with a MRI showing some microinfarcts along the pons. Treatment to date has included physical therapy, home exercise, TENS, and medications. Currently, per the documentation of 02/25/15, the injured worker complains of neck and low back pain. Nausea, vomiting, vertigo, and muscle spasms were also noted. The documentation indicated the injured worker had good days and bad days. The physical examination revealed mild pain with facet loading bilaterally. The treating physician requested authorization for a neck pillow, cervical traction with air bladder, IF/muscle stimulator/TENS unit with conductive garment and replacement pads, low back brace, hot and cold wrap, Tramadol ER 150mg #30, Trazadone 50mg #60, Nalfon 400mg #60, and Protonix 20mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neck Pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (<http://www.odgtwc.com/odgtwc/neck.htm>).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Pillow.

Decision rationale: The Official Disability Guidelines indicate the use of a neck support pillow is recommended while sleeping in conjunction with daily exercise. The injured worker should be taught exercises and the appropriate use of a neck pillow during sleep. The clinical documentation submitted for review failed to indicate the injured worker had exercises and had been taught the appropriate use of a neck support pillow. Given the above, the request for a neck pillow is not medically necessary.

Cervical traction with air bladder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 173.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Traction (mechanical).

Decision rationale: The Official Disability Guidelines indicate that injured worker controlled traction is appropriate for injured workers with radicular symptoms in conjunction with a home exercise program. The clinical documentation submitted for review failed to indicate the injured worker had radicular symptoms. There was a lack of documentation indicating the injured worker would utilize a traction unit in conjunction with a home exercise program. Additionally, the request as submitted failed to indicate whether the unit was for a rental or purchase. Given the above, the request for cervical traction with air bladder is not medically necessary.

IF/ Muscle Stimulator/ TENS unit with conductive garment and replacement pads: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, NMES, Interferential Current Stimulation Page(s): 114-116, 121, 118.

Decision rationale: The California Medical Treatment Utilization Schedule recommends a one month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there, must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. They do not recommend Neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its use in chronic pain. They do not

recommend Interferential Current Stimulation (ICS) as an isolated intervention. The guidelines further indicate that a formfitting TENS device is medically necessary when there is documentation there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment, or that the injured worker had a medical condition that prevents the use of a traditional system. There was a lack of documented rationale for the conductive garment. There was a lack of documentation to warrant non-adherence to guideline recommendations. Additionally, as the unit is not medically necessary, the replacement pads would not be supported. Given the above, the request for an IF/ Muscle Stimulator/TENS unit with conductive garment and replacement pads is not medically necessary.

Low Back Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The American College of Occupational and Environmental Medicine guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, continued use of back braces could lead to deconditioning of the spinal muscles. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for a low back brace is not medically necessary.

Hot and Cold Wrap: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) http://www.odg-twc.com/odgtwc/low_back.htm.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

Decision rationale: The ACOEM Guidelines indicate at home local applications of cold packs during the first few days of acute complaints are appropriate, and thereafter, applications of heat packs. The clinical documentation submitted for review failed to provide a necessity for a hot and cold wrap versus the use of at home applications of heat and cold packs. There was a lack of documented rationale for the use of the hot and cold wrap. Given the above, the request for a hot and cold wrap is not medically necessary.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, opioid dosing Page(s): 60, 78, 86.

Decision rationale: The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker was being monitored for aberrant drug behavior. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for tramadol ER 150 mg, #30, is not medically necessary.

Trazodone 50mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 13.

Decision rationale: The California MTUS guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes in the use of other analgesic medications, sleep quality and duration and psychological assessments. The clinical documentation submitted for review failed to provide documentation of an objective decrease in pain and objective functional improvement, including an assessment in the changes in the use of other analgesic medications, sleep quality and duration, and psychological assessments. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for trazodone 50 mg, #60, is not medically necessary.

Nalfon 400mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS guidelines indicate that NSAIDS are recommended for short term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the

requested medication. Given the above, the request for Nalfon 400 mg, #60, is not medically necessary.

Protonix 20mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California MTUS guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are also for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide documentation of signs and symptoms of dyspepsia. The duration of use could not be established. The request as submitted failed to indicate the frequency for the requested medication. As the NSAID was found to be not medically necessary, the request for Protonix would not be supported. Given the above, the request for Protonix 20 mg, #60, is not medically necessary.