

Case Number:	CM15-0066937		
Date Assigned:	05/14/2015	Date of Injury:	08/07/2014
Decision Date:	09/21/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	04/08/2015

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

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 29 year old male, who sustained an industrial injury on 8/7/14. The diagnoses have included cervical disc displacement, cervical disc protrusion, cervical dysfunction, cervical strain/sprain, lower extremity neuritis, lumbar disc displacement, lumbar facet arthropathy, lumbar radiculopathy and insomnia. Treatment to date has included medications, topical analgesics, diagnostics, physical therapy, Functional Capacity Evaluation (FCE), and activity restrictions. Currently, as per the physician progress note dated 2/25/15, the injured worker complains of neck pain with stiffness and heaviness and numbness and tingling. He also complains of stabbing low back pain with stiffness and heaviness rated 7/10 on pain scale. The objective findings reveal the cervical spine range of motion are decreased and painful with tenderness to palpation and muscle spasm. The lumbar spine range of motion is decreased and painful with tenderness to palpation and muscle spasm. The orthopedic test Nachlas and Milgram's tests are positive bilaterally. There are psychological complaints. The diagnostic testing that was performed included x-ray of the thoracic spine dated 11/1/14 reveals scoliosis. The x-ray of the lumbar spine dated 11/1/14 reveals restricted range of motion and mild left lateral list of the lumbar spine. The x-ray of the lumbar spine dated 3/5/15 reveals levoconvex lumbar scoliosis. The x-ray of the cervical spine dated 3/3/15 reveals straightening of the cervical lordosis. Magnetic Resonance Imaging (MRI) of the cervical spine dated 12/3/14 reveals degenerative disc disease and disc protrusion. Work status is to remain off work until 4/11/15. The physician requested treatments included a Cold unit, Cyclobenzaprine 2%, Flurbiprofen,

Gabapentin 15%, Amitriptyline, Dextromethorphan, 1 Interferential unit, 1 caudal epidural injection, and 1 referral to orthopedic physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 173-4, 300, 161.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Cold/heat packs.

Decision rationale: According to the Official Disability Guidelines, there is minimal evidence supporting the use of cold therapy except in the acute phase of an injury or for the first seven days postoperatively. The injury is long past the acute phase and the unit is not ordered for postoperative purposes. Cold unit is not medically necessary.

Cyclobenzaprine 2%, Flurbiprofen: Upheld

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

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

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no evidence for use of any muscle relaxant as a topical product. Cyclobenzaprine 2%, Flurbiprofen is not medically necessary.

Gabapentin 15%, Amitriptyline, Dextromethorphan: Upheld

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

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

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not

recommended. There is no peer-reviewed literature to support use. Gabapentin 15%, Amitriptyline, Dextromethorphan is not medically necessary.

1 Interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: According to the MTUS an 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. A TENS unit without interferential current stimulation is the recommended treatment by the MTUS. 1 Interferential unit is not medically necessary.

1 caudal epidural injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The medical record does contain documentation of radiculopathy which is corroborated by imaging studies. I am reversing the previous utilization review decision. 1 caudal epidural injection is medically necessary.

1 referral to ortho: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines Chapter 7, Independent Medical Examinations and Consultations, Page 127.

Decision rationale: According to the MTUS, a consultation is ordered to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consult it is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment

of an examinee or patient. The medical record lacks sufficient documentation and does not support a referral request. 1 referral to ortho is not medically necessary.