

Case Number:	CM15-0086748		
Date Assigned:	05/11/2015	Date of Injury:	08/25/2011
Decision Date:	09/15/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	05/05/2015

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: Emergency 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 44 year old female, who sustained an industrial/work injury on 8/25/11. She reported initial complaints of back pain, left lower extremity pain and shoulder pain. The injured worker was diagnosed as having neck sprain/strain, brachial neuritis or radiculitis, displacement of cervical intervertebral disc without myelopathy, superior glenoid labrum lesions, thoracic sprain and strain, sprain and strain of sacroiliac. Treatment to date has included medication, physical therapy, and chiropractic therapy. Currently, the injured worker complains of pain, spasm, interrupted sleep, and work performance. Per the primary physician's progress report (PR-2) on 3/27/15, examination revealed tenderness and spasm in the low back and paraspinal areas with positive straight leg raise at unspecified level. There was also tenderness in the periscapular area around the left shoulder. The requested treatments include Ultram, Zanaflex, Aquatic therapy, Psyche consultation, and Internal Medicine consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50mg 1 by mouth every 6 hours as needed, #120: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Page(s): 78, 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-83 of 127.

Decision rationale: Tramadol is a pain medication in the category of a centrally acting analgesic. They exhibit opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Centrally acting drugs are reported to be effective in managing neuropathic type pain although it is not recommended as first line therapy. The side effect profile is similar to opioids. For chronic back pain, it appears to be efficacious for short-term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. The use of tramadol for osteoarthritis is indicated for short-term use only (<3 months) with poor long-term benefit. In this case, the patient does not meet the qualifying criteria or indications. As such, the request is not medically necessary.

Zanaflex 2mg, 1-2 by mouth, three (3) times per day as needed, #120: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63, 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63 of 127.

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate qualifying evidence for use of a muscle relaxant, the request is not medically necessary.

Aquatic Therapy 3x4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22 of 127.

Decision rationale: Recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. For recommendations on the number of

supervised visits, see Physicalmedicine. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. (Tomas-Carus, 2007) In this case, there is insufficient documentation to justify this therapy. As stated above, aquatic treatment is indicated when reduced weight bearing is desirable, as it minimizes the effects of gravity. There is no explanation in the records as to why this would be of benefit as opposed to land-based therapy. As such, the request is not medically necessary.

Psyche Consultation: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 391-392.

Decision rationale: The request is for a psychiatry referral. The ACOEM guidelines state the following: The initial assessment is a critical tool for detecting potential emotional problems that require the attention of a psychiatrist or other mental health professional to assure safe and optimal treatment. The initial screening should be focused more on recognizing indications for urgent mental health referral (red flags) than on specific psychiatric diagnosis (see Table 15-2). Red-flag indicators include impairment of mental functions, overwhelming symptoms, or signs of substance abuse. The practitioner performing the assessment is advised to keep a high index of suspicion for depression, which is a prevalent and under diagnosed condition. Absence of red-flag indicators rules out the need for urgent referral or inpatient care. In this case, there is sufficient documentation which would qualify for a psychiatric evaluation. As stated above, this is advised when red flags are seen such as a high index of suspicion for depression. As such, the request is medically necessary.

Internal medicine consultation: 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 Page(s): 78 of 127.

Decision rationale: The request is for an internal medicine consult. The MTUS guidelines do state that further consultation is appropriate in certain cases. This would include multidisciplinary pain clinic if doses of opioid medication required are beyond what is usually seen. Psychiatric consultation is indicated if there are signs of depression. In this case, there is inadequate documentation for the reasoning for an internal medicine consult. Pending further delineation of the request, it is not medically necessary.

Interferential Home Unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Interferential current therapy (IFC).

Decision rationale: The request is for the use of Interferential current therapy (IFC). The MTUS guidelines are silent regarding this issue. The ODG guidelines state the following: Under study for osteoarthritis and recovery post knee surgery. Not recommended for chronic pain or low back problems. After knee surgery, home interferential current therapy (IFC) may help reduce pain, pain medication taken, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. (Jarit, 2003) See also the Pain Chapter. A recent industry-sponsored study concluded that interferential current therapy plus patterned muscle stimulation (using the RS-4i Stimulator) has the potential to be a more effective treatment modality than conventional low-current TENS for osteoarthritis of the knee. (Burch, 2008) In this case, the patient does not qualify for the use of this product as it is under study for the recovery post knee surgery. It is not advised for chronic pain. As such, the request is not medically necessary.