

Case Number:	CM14-0146506		
Date Assigned:	09/12/2014	Date of Injury:	07/16/2014
Decision Date:	10/14/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	09/09/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 45-year-old male with date of injury of 07/16/2014. According to this report, the patient complains of neck pain, upper, mid, and low back pain with stiffness. The examination shows tenderness to palpation over the paraspinal musculature and trapezius muscles bilaterally. Axial compression tests elicits localized pain. Tenderness to palpation is present with muscle spasms over the paraspinal musculature bilaterally in the thoracic and lumbar spine. Straight leg raise elicits localized pain. Sensation to pinprick and light touch in the bilateral upper and lower extremities are decreased along the left C5 dermatome. Motor testing of the major muscle groups of the bilateral upper and lower extremities reveals no weakness. The utilization review denied the request on 09/02/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox DS 550mg QTY: 60.00 (UR): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Anti-inflammatory medications, NSAIDs (non-steroidal anti-inflamma.

Decision rationale: This patient presents with neck, upper, mid, and lower back pain. The physician is requesting Anaprox DS 550 mg quantity 60. The MTUS guidelines page 22 on anti-inflammatory medications, states that anti-inflammatories are the traditional first line treatment to reduce pain, so activity and functional restoration can resume, but long-term use may not be warranted. The utilization review denied the request stating that NSAIDs are recommended for short-term use only. The records show that the patient has not tried NSAIDs in the past. In this case, MTUS recommends NSAIDs as first-line treatment for pain and inflammation. Therefore, the request for Anaprox DS 550mg qty: 60.00 (UR) is medically necessary and appropriate.

AVID IF unit with supplies QTY:1.00(UR): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): p118-120.

Decision rationale: This patient presents with neck, upper, mid, and lower back pain. The physician is requesting Avid IF unit with supplies. The MTUS guidelines page 118 to 120 states that interferential current stimulation 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. In addition, a one-month trial may be appropriate to permit the treater to study the effects and benefits of its use. The documents show that the patient has not tried an IF unit. MTUS requires a trial of an IF unit to determine its efficacy in terms of function and pain reduction. Therefore, the request for AVID IF unit with supplies qty:1.00(UR) is not medically necessary and appropriate.

Electrodes QTY: 8.00(UR): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): p118-120.

Decision rationale: This patient presents with neck, upper, mid, and lower back pain. The physician is requesting electrodes for the Avid IF Unit. The MTUS guidelines page 118 to 120 states that interferential current stimulation 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. Given that the patient's request for an Avid IF unit has been denied, the request for electrodes to be used in this unit is not necessary.

Batteries QTY: 24.00(UR): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): p118-120.

Decision rationale: This patient presents with neck, upper, mid, and lower back pain. The physician is requesting batteries for the Avid IF Unit. The MTUS guidelines page 118 to 120 states that interferential current stimulation 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. Given that the patient's request for an Avid IF unit has been denied, the request for batteries to be used in this unit is not necessary.

Adhesive Remover Wipes QTY: 32.00(UR): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): p118-120.

Decision rationale: This patient presents with neck, upper, mid, and lower back pain. The physician is requesting adhesive remover wipes for the Avid IF Unit. The MTUS guidelines page 118 to 120 states that interferential current stimulation 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. Given that the patient's request for an Avid IF unit has been denied, the request for adhesive remove wipes to be used with this unit is not necessary.

Lead wires (Pair) QTY: 1.00(UR): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): p118-120.

Decision rationale: This patient presents with neck, upper, mid, and lower back pain. The physician is requesting lead wires for the Avid IF Unit. The MTUS guidelines page 118 to 120 states that interferential current stimulation 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. Given that the patient's request for an Avid IF unit has been denied, the request for lead wires to be used in this unit is not necessary.

Norco 5/325 QTY: 60.00(UR): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78.

Decision rationale: This patient presents with neck, upper, mid, and lower back pain. The physician is requesting Norco 5/325 quantity 60. The MTUS guidelines page 76 to 78 under criteria for initiating opioids recommend that reasonable alternatives have been tried, consider the patients likelihood of improvement, likelihood of abuse, etc. MTUS goes on to state that baseline pain and functional assessment should be provided, once that criteria has been met, a new course of opioids maybe tried. The records show that the patient has not tried Norco in the past. While a trial may be reasonable, the treater does not discuss failure of alternative treatments including NSAIDs. This patient's injury is fairly recent and the patient has not tried the Anaprox yet. Therefore, the request for Norco 5/325 qty: 60.00(UR) is not medically necessary and appropriate.

Fexmid 7.5mg QTY:60.00(UR): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Page(s): 64.

Decision rationale: This patient presents with neck, upper, mid, and lower back pain. The physician is requesting Fexmid 7.5 mg quantity 60. The MTUS guidelines on pages 63 to 66 on muscle relaxants states that it recommends non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic lower back pain. Furthermore, under Cyclobenzaprine, MTUS states that it is recommended for a short course of therapy with limited mixed evidence. It does not allow for chronic use. The records show that the patient has not tried cyclobenzaprine in the past. While a trial is reasonable, the requested quantity exceeds MTUS recommended short course treatment. Therefore, the request for Fexmid 7.5mg qty:60.00(UR) is not medically necessary and appropriate.

Physical therapy QTY: 8.00(UR): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

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

Decision rationale: This patient presents with neck, upper, mid, and lower back pain. The physician is requesting eight physical therapy sessions. The MTUS guidelines page 98 and 99 on physical medicine recommends 8 to 10 visits for myalgia, myositis, and neuralgia type symptoms. The records show that the patient has not tried physical therapy in the past. The utilization review modified the request to four visits. In this case, a trial of physical therapy is reasonable. Therefore, the request for physical therapy qty: 8.00(UR) is medically necessary and appropriate