

<b>Case Number:</b>	CM15-0014495		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	09/10/2014
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	12/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/26/2015

### 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: 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 23-year-old male who reported an injury on 09/10/2014. The mechanism of injury involved heavy lifting. The current diagnoses include thoracic strain, lumbar strain, and back spasm. The injured worker presented on 12/02/2014 with complaints of persistent lower back pain. Previous conservative treatment included 6 sessions of physical therapy. The injured worker was utilizing ibuprofen and Flexeril. Upon examination, there was tenderness about the left side of the thoracic and proximal lumbar paravertebral muscles, mild spasm, flexion of the fingertips to just below the knees, extension to 30 degrees, lateral flexion to 45 degrees, lateral rotation to 30 degrees, 5/5 motor strength, and a negative straight leg raise. Recommendations included an MRI of the lumbar spine and a referral to a pain management specialist. The injured worker was issued a refill of ibuprofen, Flexeril, and Biofreeze gel. There was no Request for Authorization form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy (PT) three times a week for four weeks for the lumbar spine:** Upheld

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

**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. According to the documentation provided, the injured worker has failed to respond to conservative management, including physical therapy. Without documentation of significant functional improvement, additional therapy would not be supported. As such, the request is not medically appropriate.

**Meds 4 Unit with Garment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation <http://www.igmedsupply.com/lg4in1qucote.html>

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** The California MTUS Guidelines do not recommend transcutaneous electrotherapy as a primary treatment modality, but a 1 month home based trial may be considered as a noninvasive conservative option. In this case, it is noted that the injured worker has failed to respond to conservative management, including physical therapy. However, there was no documentation of a successful 1 month trial prior to the request for a unit purchase. Given the above, the request is not medically appropriate.

**Flexeril 7.5mg #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter

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

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. The injured worker has continuously utilized Flexeril for an unknown duration. The injured worker continues to present with mild muscle spasm upon examination. There was also no frequency listed in the request. Given the above, the request is not medically appropriate.

**Protonix 20mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 68-69.

**Decision rationale:** The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the injured worker does not meet criteria for the requested medication. Additionally, there was no frequency listed in the request. Given the above, the request is not medically appropriate.