

Case Number:	CM15-0116799		
Date Assigned:	06/25/2015	Date of Injury:	11/25/2014
Decision Date:	07/24/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	06/17/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 39 year old female who reported an industrial injury on 11/25/2014. Her diagnoses, and/or impressions, are noted to include: herniated nucleus pulposus; thoracic and lumbar musculoligamentous sprain/strain; moderate-severe bilateral lumbar disc protrusion and neuro-foraminal stenosis, with radiating lower extremity pain. Current magnetic imaging studies of the lumbosacral spine were done on 4/23/2015. Her treatments are noted to include multi-modality physiotherapy for the lumbar spine; acupuncture treatments for the lower back; medication management; and rest from work. The progress notes of 5/29/2015 reported constant mild-moderate low back pain that radiated to the bilateral lower extremities, right > left, with burning in the right foot and numbness/tingling in the left thigh/foot. Objective findings were noted to include tenderness over the para-vertebral musculature and lower thoracic region, right > left, with guarding and decreased range-of-motion; tenderness over the para-vertebral musculature, lumbosacral junction, right sciatic notch and gluteal musculature, right > left, tenderness over the right sacroiliac joint with para-spinal mild muscle spasms, positive bilateral straight leg raise, positive right sacroiliac stress test, and decreased range of motion; and decreased sensation with weakness to the lower extremities. The physician's requests for treatments were noted to include chiropractic sessions to reduce pain, spasm and inflammation; a home interferential unit for consistent, self-guided treatment of flare-ups; and the continuation Fexmid, Anaprox, Ultram and Neurontin, for spasms, inflammation, pain and chronic pain and neuropathic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 chiropractic visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58.

Decision rationale: According to the MTUS guidelines, Chiropractic therapy is considered manual therapy. It is recommended for chronic musculoskeletal pain. For Low back pain, therapeutic care is for 6 visits over 2 weeks with functional improvement up to a maximum of 18 visits over 8 weeks. The therapeutic benefit of the modalities was not specified. As a result additional chiropractor therapy is not necessary. In this case, the claimant had undergone therapy and medication management for back pain. Although chiropractor therapy may be appropriate, the requested amount exceeds the 6 initial visits recommended to determine therapeutic benefit. As a result, the request above is not medically necessary.

Home 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 IF unit Page(s): 118.

Decision rationale: According to the guidelines an IF unit 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. In this case, there was not a mention for return to work or exercise plan along with the use if an IF unit. Utilization details and length of treatment were not specified. The request for the IF unit is not medically necessary.

60 Fexmid 7.5mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, Chronic Pain Treatment Guidelines muscle relaxants.

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

Decision rationale: According to the MTUS guidelines, Cyclobenzaprine (Fexmid) is more effective than placebo for back pain. It is recommended for short course therapy and has the greatest benefit in the first 4 days suggesting that shorter courses may be better. Those with fibromyalgia were 3 times more likely to report overall improvement, particularly sleep. Treatment should be brief. There is also a post-op use. The addition of Cyclobenzaprine to other agents is not recommended. The claimant had been on Fexmid for over a month in combination with NSAIDs and opioids. Prolonged use is not within the guidelines and is not medically necessary.