

Case Number:	CM15-0072442		
Date Assigned:	04/22/2015	Date of Injury:	09/16/2014
Decision Date:	06/11/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/16/2015

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: Texas, Illinois

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 33 year old female, who sustained an industrial injury on September 16, 2014. The injured worker was diagnosed as having lumbar radiculopathy, lumbar, hip and ankle sprain/strain and insomnia. Treatment to date has included medication and physical therapy. A progress note dated March 2, 2015 provides the injured worker complains of low back pain rated 2/10 without medication and 2-3/10 with medication. The pain radiates down the legs with numbness and tingling. She left hip pain rated 8/10 without medication and 0-1/10 with medication and left ankle pain rated 4-5/10 without medication and 1/10 with medication. The injured worker reports loss of sleep due to pain. Physical exam notes tenderness and decreased range of motion (ROM) in all affected areas. The plan includes acupuncture, medication and durable medical equipment (DME).

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot / Cold Unit purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medline, Cinahl, and The Cochrane Library.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG Ankle & Foot (Acute & Chronic) Continuous-flow cryotherapy.

Decision rationale: The injured worker sustained a work related injury on September 16, 2014. The medical records provided indicate the diagnosis of lumbar radiculopathy, lumbar, hip and ankle sprain/strain and insomnia. Treatment to date has included medication and physical therapy. The medical records provided for review do not indicate a medical necessity for Hot / Cold Unit purchase. The MTUS is silent on the use of continuous heat or cold unit (Continuous-flow cryotherapy), though it recommends at home use of this therapy. The Official Disability guidelines recommends its use in the post operative setting within 7 days of surgery, but recommends against using it in other conditions.

Acupuncture 2x4: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The injured worker sustained a work related injury on September 16, 2014. The medical records provided indicate the diagnosis of lumbar radiculopathy, lumbar, hip and ankle sprain/strain and insomnia. Treatment to date has included medication and physical therapy. The medical records provided for review do not indicate a medical necessity for Acupuncture 2x4. The requested treatment exceeds the MTUS recommendation of time to produce functional improvement: 3 to 6 treatments; Frequency: 1 to 3 times per week; Optimum duration: 1 to 2 months. To extend treatment based on documentation of functional improvement.

Tramadol 150mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-81.

Decision rationale: The injured worker sustained a work related injury on September 16, 2014. The medical records provided indicate the diagnosis of lumbar radiculopathy, lumbar, hip and ankle sprain/strain and insomnia. Treatment to date has included medication and physical therapy. The medical records provided for review does not indicate a medical necessity for Tramadol 150mg #60. The MTUS recommends the use of the lowest dose of opioids for the short term treatment of moderate to severe pain. The MTUS does not recommend the use of opioids for longer than 70 days in the treatment of chronic pain due to worsening adverse effects and lack of research in support of benefit. Also, the MTUS recommends that individuals on

opioid maintenance treatment be monitored for analgesia (pain control), activities of daily living, adverse effects and aberrant behavior; the MTUS recommends discontinuation of opioid treatment if there is no documented evidence of overall improvement or if there is evidence of illegal activity or drug abuse or adverse effect with the opioid medication. The medical records indicate the injured worker's use of opioids predates 11/2014, but the injured worker has not made functional improvement: the worker has remained off work, though there is significant improvement in pain with the use of the medications. The injured worker is not properly monitored for adverse effects, pain control (based on the guidelines recommendation), aberrant behavior and activities of daily living.