

Case Number:	CM14-0140046		
Date Assigned:	09/10/2014	Date of Injury:	07/10/2007
Decision Date:	10/21/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/29/2014

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 Emergency Medicine and is licensed to practice in Texas. 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 injured worker is a 53-year-old female who reported an injury on 07/10/2007 while working as a professor at the college and was out weed eating using a weed eater that weighed approximately 40 pounds when she felt a loss of grip. The injured worker complained of lower back pain radiating to the left leg. The injured worker had a diagnosis of depression with anxiety, pain psychogenic, degeneration lumbar/lumbosacral disease, sciatica, postlaminectomy syndrome, reactive depression, and left sciatica. The medications included Meloxicam, Prozac, Dilaudid, Tizanidine, Ibuprofen, and Sprix nasal spray. The prior treatments included cognitive behavioral therapy, injections, additional physical therapy, acupuncture, and medications. The objective findings dated 06/03/2014 revealed no evidence of sedation; mood was relatively positive; there was a well healed lumbar spine surgical scar; and limitations in range of motion at the lumbar spine; gait was slightly antalgic with weight bearing favored to the right leg and ambulating with a cane. Diagnostic studies included an MRI of the cervical spine dated 09/20/2007 and an MRI of the lumbar spine dated 07/01/2008. The treatment plan included a TENS unit, neck support, back support, cervical traction with an air bladder, MRI of the left knee, MRI of the left hip, adjustable chair, hot and cold wrap, Terocin patch, below Lidopro cream, and Flexeril. The Request for Authorization dated 09/10/2014 was submitted with the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENs Page(s): 116.

Decision rationale: The request for a TENS unit is not medically necessary. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 month home based TENS trial may be considered as a noninvasive conservative option if used in conjunction to a program of evidence based functional restoration. The results of studies are inconclusive. The published trials do not provide information on the stimulation parameters which are most likely to provide optimal pain relief or do not answer questions about long term effects. The documentation did not indicate that the injured worker had failed conservative care or that the injured worker had a 30 day trial period. As such, the request is not medically necessary.

Neck support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Collars (cervical)

Decision rationale: The request for a neck support is not medically necessary. The California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines indicate that cervical collars are not recommended for neck strains or patients with whiplash. Whereas immobilization using neck collars are less effective and not recommended for treating whiplash patients, cervical collars are frequently used after surgical procedures and in the emergency setting following suspected trauma of the neck or is essential that the appropriately sized brace be selected that properly fits the patient. Studies demonstrate how increasing the height of the orthosis provides greater restriction of range of motion but may also force the neck into relative extension because functional range of motion is effective to a lesser degree than full active cervical motion. Any changes in collar height may not be clinically relevant for other patients, such as those who have undergone operations for degenerative diseases. As such, the request is not medically necessary.

Lumbar Support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic

Decision rationale: The request for lumbar support is not medically necessary. The California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines indicate that lumbar support is not recommended for prevention. There is strong consistent evidence that lumbar supports were not effective in preventing neck and back pain. The clinical notes indicated that the injured worker just had some limited range of motion; no functional measurements for the back pain. As such, the request is not medically necessary.

Cervical traction with air bladder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Collars (cervical)

Decision rationale: The request for a neck support is not medically necessary. The California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines indicate that cervical collars are not recommended for neck strains or patients with whiplash. Whereas immobilization using neck collars are less effective and not recommended for treating whiplash patients, cervical collars are frequently used after surgical procedures and in the emergency setting following suspected trauma of the neck or is essential that the appropriately sized brace be selected that properly fits the patient. Studies demonstrate how increasing the height of the orthosis provides greater restriction of range of motion but may also force the neck into relative extension because functional range of motion is effective to a lesser degree than full active cervical motion. Any changes in collar height may not be clinically relevant for other patients, such as those who have undergone operations for degenerative diseases. As such, the request is not medically necessary.

MRI of the left knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC, Knee and Leg Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, MRI's (magnetic resonance imaging)

Decision rationale: The request for an MRI of the left knee is not medically necessary. The California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines recommend as indicated below: for acute trauma to the knee, nonpatellofemoral symptoms, an

initial anteroposterior and posterior lateral radiograph was a nondiagnostic study; if internal derangement is suspected, nontraumatic knee pain in an adult for nontrauma, nontumor, nonlocalized pain, if initial anteroposterior and lateral radiograph nondiagnostic demonstrated normal findings or a joint effusion, if additional studies are indicated, and if an internal derangement is suspected; nontraumatic knee injury or knee pain, nontrauma, nontumor, nonlocalized pain, and if initial anteroposterior and lateral radiographs demonstrated evidence of internal derangement. As such, the request is not medically necessary.

MRI of the left hip: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC, Hip & Pelvis Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, MRI (magnetic resonance imaging)

Decision rationale: The request for an MRI of the left hip is not medically necessary. The California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines recommend as indicated below: MRI is the most accepted form of imaging for finding avascular necrosis of the hip or osteonecrosis. The MRI is both highly sensitive and specific for detection of many abnormalities involving the hip or surrounding soft tissue and should be, in general, the first imaging technique employed following plain films. The clinical notes did not indicate that the injured worker had a history or diagnosis or signs and symptoms of any hip complaints. No imaging was available. No plain films were available for review. As such, the request is not medically necessary.

Adjustable chair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Durable medical equipment (DME)

Decision rationale: The request for an adjustable chair is not medically necessary. The California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines indicate that durable medical equipment is recommended generally if there is a medical need and if a device or system meets Medicare's definition of durable medical equipment (below). The term durable medical equipment is defined as equipment which could withstand repeated use, as in could normally be rented and used by successive patients; is primarily and customarily used to serve a medical purpose; and is generally not useful to a person in the absence of illness or injury, as well as is appropriate for use in the patient's home. The clinical information did not

indicate that the injured worker had a need for an adjustable chair nor does it meet the Medicare criteria. As such, the request is not medically necessary.

Hot and cold wrap: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, cold/hot packs

Decision rationale: The request for a hot and cold wrap is not medically necessary. The California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines indicate that cold/heat packs are recommended as an option for acute pain. Recommend at home local applications of cold packs in the first few days of acute complaint; thereafter applications of heat or cold packs. Continuous low level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating lower back pain. The evidence for the application of cold treatment to lower back pain is more limited than heat therapy, with only 3 poor quality studies located that support its use, but studies confirm that it may be a low risk, low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful, and for pain reduction, the return of normal function. The clinical notes did not indicate that the injured worker had had an acute injury. The injury that the injured worker sustained was in 2007. The request did not address the body location for the hot and cold wrap. As such, the request is not medically necessary.

Terocin patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111-113.

Decision rationale: The request for Terocin patch is not medically necessary. The California MTUS indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate that Terocin patches are not indicated. The request did not indicate the frequency, dosage, or duration. As such, the request is not medically necessary.

Lidopro cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The request for Lidopro cream is not medically necessary. The California MTUS indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate that Lidopro cream is not indicated. The request did not indicate the frequency, dosage, or duration. As such, the request is not medically necessary.

Flexeril 7.5 mg qty 20 from 8-11-2014 to 8-21-2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41.

Decision rationale: The request for Flexeril 7.5 mg quantity 20 from 08/11/2014 to 08/21/2014 is not medically necessary. The California MTUS Guidelines recommend Flexeril as an option for a short course of therapy. The greatest effect of this medication is within the 4 days of treatment, suggesting that a shorter course may be better. Treatment should be brief. The documentation provided lacked objective functional improvement with the medication or the length of time that the injured worker was taking the Flexeril. The request did not indicate the frequency. As such, the request is not medically necessary.