

Case Number:	CM13-0021744		
Date Assigned:	12/27/2013	Date of Injury:	11/22/2009
Decision Date:	02/27/2014	UR Denial Date:	09/03/2013
Priority:	Standard	Application Received:	09/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 physician 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 46-year-old female who report an injury on 11/22/2009. The patient is diagnosed with history of cervical spine strain and sprain, cervical spine disc disease, thoracic spine musculoligamentous strain and sprain, history of lumbosacral musculoligamentous strain and sprain, lumbar spine disc disease, history of left shoulder sprain and strain, left shoulder tendinosis, left shoulder impingement syndrome, status post left shoulder surgery in 2012, history of left elbow medial epicondylitis, left wrist sprain and strain, left wrist carpal tunnel syndrome, and left hip strain versus lumbar spine radiculitis. The patient was seen by [REDACTED] on 07/22/2013. The patient reported persistent pain to multiple areas of the body. Physical examination revealed tenderness to palpation over the cervical, thoracic, and lumbar spine as well as the left upper and lower extremity. Treatment recommendations included physical therapy to the lumbar spine and left shoulder 3 times per week for 4 weeks, continuation of FluriFlex cream, Medrox patch, naproxen, cyclobenzaprine, omeprazole, and tramadol as well as an interferential unit and cold and hot unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDS are recommend for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. As per the documentation submitted, the patient does not maintain a diagnosis of osteoarthritis. There is no indication of a failure to respond to first line treatment with acetaminophen as recommended by California MTUS Guidelines. Additionally, California MTUS Guidelines state there is no evidence of long-term effectiveness for pain or function. Based on the clinical information received, the request is non-certified.

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: 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 is no indication of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the use of a proton pump inhibitor. As such, the request is non-certified.

Physical therapy to the lumbar spine and left shoulder, three times per week for four weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Physical Therapy.

Decision rationale: 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. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. Official Disability Guidelines state treatment for impingement syndrome includes 10 visits over 8 weeks. As per the documentation submitted, the patient's physical examination on the requesting date of 07/22/2013 only revealed tenderness to palpation. There was no documentation of a significant musculoskeletal or neurological deficit that would warrant the need for skilled physical medicine treatment. Additionally, the request for physical therapy 3 times per week for 4 weeks exceeds

guideline recommendations. Based on the clinical information received, the request is non-certified.

IF Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: California MTUS Guidelines state interferential current stimulation is not recommended as an isolated intervention. There should be documentation that pain is ineffectively controlled due to diminished effectiveness of medications or side effects, a history of substance abuse or significant pain from postoperative conditions. As per the documentation submitted, there is no indication that this patient has failed to respond to conservative treatment. There is also no evidence of a successful 1 month trial period. There is also no evidence of a treatment plan with the specific short and long-term goals of treatment with the unit. Based on the clinical information received, the request is non-certified.

Cold/hot unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. At home local applications of heat or cold are as effective as those performed by therapist. As per the clinical documentation submitted, the patient's physical examination on the requesting date of 07/22/2013 only revealed tenderness to palpation. There is no clear rationale as to why the patient would not benefit from at home self application of hot and cold therapy. The medical necessity has not been established. As such, the request is non-certified.

Medrox patch #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are

primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of neuropathic pain upon physical examination. There is also no indication of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. Based on the clinical information received, the request is non-certified.

Cyclobenzaprine 7.5 mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. There was no documentation of palpable muscle spasm, spasticity, or muscle tension upon physical examination. As guidelines do not recommend long-term use of this medication, the request cannot be determined as medically appropriate. As such, the request is non-certified.