

Case Number:	CM13-0022401		
Date Assigned:	09/08/2014	Date of Injury:	12/20/2010
Decision Date:	10/09/2014	UR Denial Date:	08/20/2013
Priority:	Standard	Application Received:	09/10/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas and Ohio. 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 55-year-old male who reported an injury on 12/20/2010 due to being hit with a hydraulic nozzle that came out of a manhole to the left knee. The injured worker has diagnoses of moderate left shoulder impingement syndrome, acromioclavicular joint separation, left shoulder, status post arthroscopy of the left knee with partial medial and lateral meniscectomy, status post arthroscopy and medial arthrotomy of the left knee with partial medial meniscectomy, lumbar spine pain and left shoulder pain. Past medical treatment consisted of chiropractic therapy, physical therapy, muscle stimulation, ultrasound, surgery, home exercise program, the use of hot/cold packs, aquatic therapy and medication therapy. Medications include Norco, Xanax, and Prilosec. On 12/14/2012, the injured worker underwent an EMG/nerve conduction study in both lower extremities. The injured worker underwent arthroscopy plus medial arthrotomy of the left knee with a partial medial meniscectomy and chondroplasty and excision of bone spurs on 03/22/2013. On 05/13/2013, the injured worker complained of neck, low back, bilateral knee and left shoulder pain. Exam of the cervical spine revealed a flexion of 30 degrees with muscle guarding and posterior neck pain, extension of 40 degrees, right rotation of 65 degrees with muscle guarding and right posterolateral base of neck pain, left rotation of 70 degrees and right lateral bending of 30 degrees. Thoracic spine range of motion had a flexion of 60 degrees, extension of 0, right and left rotation of 45 degrees bilaterally. Left shoulder range of motion revealed a flexion of 130 degrees, abduction of 130 degrees, adduction of 20 degrees, extension of 30 degrees, internal rotation of 70 degrees and external rotation of 60 degrees. Impingement sign on the left shoulder was positive, supraspinatus sign was positive, apprehension test was negative, AC joint tenderness was negative, crepitus was positive, drop arm test was negative and sulcus sign was negative. Motor strength exam was intact at 5/5 in both upper extremities. Sensation was intact to light touch including pinwheel sharp/dull

discrimination in both upper extremities. Circulation was intact in both upper extremities. Examination of the knees revealed that patellofemoral compression was positive bilaterally and there were traces on the right of patellofemoral crepitation with positive on the left. Range of motion revealed flexion on the right 120 degrees and 85 on the left, extension was 0 on the right and 8 degrees on the left. Lumbar spine range of motion had a flexion of 60 degrees, extension of 10 degrees with muscle guarding and low back pain, right tilt was 15 degrees and left tilt was 10 degrees. Straight leg raise was positive bilaterally, dorsiflexion of the foot was negative bilaterally, hamstring tightness was positive bilaterally, Patrick's sign was negative bilaterally and Faber sign was positive bilaterally. Motor strength was in normal limits, sensation was intact and circulation was intact in bilateral lower extremities. The treatment plan is for the injured worker to continue the use of medication, have an additional 12 physical therapy sessions, have a referral for pain management specialist, and undergo a Functional Capacity Evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 PHYSICAL THERAPY SESSIONS: 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 Physical Medicine Page(s): 98.

Decision rationale: The request for 12 additional physical therapy sessions is not medically necessary. The California MTUS state that active therapy is based on philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The submitted documentation lacked any indication that the injured worker had no benefit with prior course of physical therapy. There was also no indication in the submitted reports as to how many physical therapy sessions the injured worker had completed. Furthermore, there was no evidence in the submitted report indicating whether the physical therapy had helped with any functional deficits the injured worker might have had. Additionally, the request as submitted does not indicate what extremity of the injured worker would be receiving the physical therapy. As such, the request for 12 physical therapy sessions is not medically necessary.

1 REFERRAL FOR PAIN MANAGEMENT FOR THE LUMBAR SPINE AND CERVICAL SPINE EPIDURAL STEROID INJECTIONS: Upheld PRESCRIPTION OF NORCO 10/325MG, #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 Epidural steroid injections Page(s): 46.

Decision rationale: The request for 1 referral for pain management for the lumbar spine and cervical spine epidural steroid injections is not medically necessary. The California MTUS Guidelines recommend may recommend ESIs as an option for treatment of radicular pain. An epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is no information on improved function. The criteria for the use of an ESI are as followed: Signs of radiculopathy must be documented by physical examination and corroborated by imaging studies, be initially unresponsive to conservative treatment, injections should be performed using fluoroscopy, and no more than 2 nerve root levels should be injected using transforaminal blocks. The documentation submitted for review did not indicate the injured worker had a diagnosis of radiculopathy. There was also no evidence of objective findings of numbness, weakness, or loss of strength. Furthermore, the submitted documentation lacked any quantified evidence of the injured worker being initially unresponsive to conservative treatment. Given the above, the injured worker is not within the MTUS recommended guidelines for epidural steroid injections, as such, the request for 1 referral for pain management would not be warranted. Therefore, the request for 1 referral for management for the lumbar spine and cervical spine epidural steroid injections is not medically necessary.

PRESCRIPTION OF NORCO 10/325MG, #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 Opioids (Norco) Page(s): 78, 98.

Decision rationale: The request for Norco 10/325 mg is not medically necessary. California Medical Treatment Utilization Schedule Guidelines state that the usual dose is 5/500 mg 1 or 2 tablets by mouth every 4 to 6 hours as needed for pain with a max of 8 tablets per day. Guidelines also state that prescriptions should be from a single practitioner taking as directed, and all prescriptions from a single pharmacy. That the lowest dose should be prescribed to improve pain and function. The MTUS also state that there should be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the injured worker's decreased pain, an increased level of function or improved quality of life. The use of drug screening or inpatient treatment with issues of abuse, addiction or poor pain control is recommended. The submitted documentation did not indicate side effects the injured worker may have had with the medication. There was also no evidence that the Norco was helping with any functional deficits the injured worker had. Furthermore, there was no evidence of what the injured worker's pain levels were before, during and after the medication. Guidelines also

indicate that there should be the use of drug screen or urinalysis submitted for review, the documentation lacked evidence of this. The request as submitted did not indicate the frequency or duration of the medication. Given the above, the injured worker was not within the MTUS recommended guidelines. As such, the request for Norco 10/325 mg is not medically necessary.

PRESCRIPTION OF XANAX 1MG, #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 Xanax, Benzodiazepines Page(s): 24.

Decision rationale: The request for Xanax 1 mg is not medically necessary. The California MTUS Guidelines do not recommend the use of benzodiazepines for long term use because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit the use to 4 weeks. The submitted documentation dated 04/20/2013 indicated that the injured worker had a prescription of Xanax since at least this time, exceeding the guideline recommendations for short term therapy. There was also a lack of efficacy of the medication documented to support the continued use of medication. Additionally, the request as submitted does not indicate a frequency or duration of the medication. As such, based on the documents provided for review, the request is not medically necessary.

PRESCRIPTION OF PRILOSEC 20MG, #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 Prilosec GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request for Prilosec 20 mg is not medically necessary. The California MTUS Guidelines recommend proton pump inhibitors for injured workers at risk for gastrointestinal events. Proton pump inhibitors may be recommended for patients with dyspepsia secondary to NSAID therapy or for those taking NSAID medications that are at moderate to high risk for gastrointestinal events. The submitted documentation did not indicate that the injured worker had signs of dyspepsia secondary to NSAID therapy. Furthermore, there was no evidence indicating that the injured worker might be at high risk for gastrointestinal events. The request as submitted also did not indicate a duration or frequency of the medication. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request for Prilosec 20 mg is not medically necessary.

1 FUNCTIONAL CAPACITY EVALUATION: 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 Cornerstones of Disability Prevention and Management Page(s): 77-89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional Capacity Evaluation

Decision rationale: The request for Functional Capacity Evaluation is not medically necessary. The California MTUS/ACOEM state that a Functional Capacity Evaluation may be necessary to obtain a more precise delineation of a patient's capabilities. The Official Disability Guidelines further state that a Functional Capacity Evaluation is recommended and may be used prior to admission to a work hardening program with preference for assessment tailored to a specific task for job. Functional Capacity Evaluations are not recommended for routine use. The submitted documentation lacked any objective findings upon physical examination demonstrating significant functional deficits. The documentation also lacked evidence of how a Functional Capacity Evaluation would aid the provider in an evolving treatment plan or goals. Furthermore, there was no indication of the injured worker attending a work hardening program. Additionally, there lacked quantified evidence of other treatments the injured worker underwent previously and the measurement of progress, as well as efficacy of those treatments. As such, the request for 1 Functional Capacity Evaluation is not medically necessary.