

Case Number:	CM13-0023723		
Date Assigned:	11/15/2013	Date of Injury:	11/01/2006
Decision Date:	04/21/2014	UR Denial Date:	08/16/2013
Priority:	Standard	Application Received:	09/12/2013

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 Orthopedic Surgery, and is licensed to practice in New Hampshire, New York, and Washington. 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 patient is a 66 year old female who sustained a work-related injury in November 2006 as the result of a fall. She injured her low back, both upper extremities, and her left leg. She describes chronic neck, back, shoulder, and left foot pain. Physical exam shows back tenderness with loss of motion. There is a positive straight leg raise and decreased sensation in both the upper and lower extremities. The patient has had two MRIs of the lumbar spine and both are very similar to each other. They show anterior listhesis at L5 with a mild 2mm disc bulge. At L5-S1, there is a 3mm disc bulge. There was no evidence of nerve root compression in the lumbar MRI. Diagnoses include cervical and thoracic strain and lumbar radiculopathy. The patient had a right shoulder arthroscopy with arthroscopic subacromial decompression in December 2007. The patient had left shoulder arthroscopy with rotator cuff repair in May 2009. The patient was also diagnosed with lumbar disc protrusion at L4-5 and L5-S1. Treatment to date includes multiple medications, activity modification, and physical therapy. Documentation of the efficacy of conservative measures is not present in the medical records. Specifically, the medical records do not contain adequate information on the functional effects of medications and physical therapy for the treatment of the patient's chronic pain. Documentation of the functional effects on each medication used is not present in the medical records. Documentation of the effects of physical therapy and other conservative modalities are not present in the medical records. There is no documentation of epidural steroid injections. There is no documentation that the patient is engaged in a functional restoration program. There is no documentation of significant functional improvement with any conservative measures mentioned in the medical records. The patient continues to have chronic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 SESSIONS OF PHYSICAL THERAPY FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: The patient is experiencing chronic pain in multiple body regions. The patient continues to have low back pain. Guidelines recommend attending physical therapy for the treatment of degenerative low back pain consisting of initial formal physical therapy visits with a transition to a home exercise program. This patient had documentation of physical therapy for the treatment of chronic low back pain. There is no documentation of the patient having improved with physical therapy. MTUS guidelines do not support the use of additional physical therapy for the treatment of chronic low back pain, or for crushing cases where initial physical therapy did not reduce the patient's pain. Criteria for additional lumbar physical therapy visits are not met. The request for 12 sessions of physical therapy for the lumbar spine is not medically necessary and appropriate.

120 NAPROSYN 550MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67.

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

Decision rationale: Naprosyn is a first-line nonsteroidal drug. The patient has had an early trial of Naprosyn. There is no documentation of any functional improvement with the previous trial. Criteria for additional Naprosyn are not met. The request for 120 Naprosyn 550mg is not medically necessary and appropriate.

60 NORCO 2.5MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: There is no indication that the patient's pain has persisted despite the use of NSAID medication. MTUS guidelines also do not recommend opioids for chronic low back pain treatment. The criteria for Norco have not been met. The request for 60 Norco 2.5mg is not medically necessary and appropriate.

60 PRILOSEC 20MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

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

Decision rationale: There is no clinical documentation that the patient has experienced adverse GI side effects from NSAID use, or that any GI risk factors are present. The medical necessity for Prilosec has not been defined in the medical records. The request for 60 Prilosec 20mg is not medically necessary and appropriate.

LUMBAR EPIDURAL STEROID INJECTION (ESI): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: Epidural steroid injection (ESI) is not medically necessary for this patient. There is no clearly defined lumbar radiculopathy. There is no clearly described nerve root deficit that corresponds to severe compression on an imaging study. MTUS criteria for an ESI have not been met. The request for a lumbar epidural steroid injection is not medically necessary and appropriate.