

Case Number:	CM13-0047009		
Date Assigned:	12/27/2013	Date of Injury:	12/18/2008
Decision Date:	02/28/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	11/04/2013

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 Internal Medicine and Cardiology, has a subspecialty in Cardiovascular Disease, 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 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 58-year-old who reported an injury on 12/18/2008. The patient is currently diagnosed with right shoulder impingement syndrome, status post right shoulder arthroscopy, and lumbar discopathy. The patient was seen by [REDACTED] on 07/29/2013. The patient reported increasing pain to the right shoulder and constant low back pain with radiation to the bilateral lower extremities. Physical examination revealed spasm with tenderness in the paralumbar musculature, muscle spasm, positive sciatic stretch testing, and positive Neer's and Hawkins testing with diminished range of motion of the left shoulder. Treatment recommendations included a lumbar Kronos back brace for support and stability and continuing of current medications including omeprazole, Indocin, hydrocodone, and transdermal cream Xoten-C.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kronos low back brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Lumbar Supports Section

Decision rationale: California MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Official Disability Guidelines state lumbar supports are not recommended for prevention, but are recommended for treatment as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and non-specific low back pain. As per the documentation submitted, there is no evidence of significant instability or spondylolisthesis, nor is there is evidence of compression fractures. Physical examination of the lumbar spine on the requesting date only revealed spasm with tenderness to palpation. The medical necessity for the requested durable medical equipment has not been established. The request for Kronos low back brace is not medically necessary or appropriate.

Urinalysis: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77, and 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Urine Drug Testing Section

Decision rationale: California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or present of illegal drugs. Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification, including the use of a testing instrument. Patients at low risk of addiction or aberrant behavior should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the documentation submitted, the patient's injury was greater than 5 years ago to date and there is no indication of non-compliance or misuse of medication. There is no evidence that this patient falls under a high risk category that would require frequent monitoring. The request for Urinalysis is not medically necessary or appropriate.

Exoten-C 0.002/10/20% #113.4 ml, to be applied to affected area 2-3 times per day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled 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 failure to respond to first-line oral medication prior to the initiation of a topical analgesic. Therefore, the patient does not meet criteria for the use of a topical analgesic. The request for Exoten-C 0.002/10/20% #113.4 ml, to be applied to affected area 2-3 times per day, is not medically necessary or appropriate.

Hydrocodone/APAP 10/325mg, 60 count, one pill to be taken every 6-8 hours as needed:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report increasing shoulder pain and constant low back pain with radiation to the bilateral lower extremities. There has been no change in the patient's physical examination that would indicate functional improvement. The request for Hydrocodone/APAP 10/325mg, 60 count, one pill to be taken every 6-8 hours as needed, is not medically necessary or appropriate.

Omeprazole 20mg, 100 count, one pill twice per day as needed: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment 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. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Based on the clinical information received, the patient does not meet criteria for the use of a proton pump inhibitor. The request for Omeprazole 20mg, 100 count, one pill twice per day as needed, is not medically necessary or appropriate.