

Case Number:	CM13-0047385		
Date Assigned:	12/27/2013	Date of Injury:	01/19/2012
Decision Date:	02/28/2014	UR Denial Date:	10/14/2013
Priority:	Standard	Application Received:	11/01/2013

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 Physical Medicine and Rehabilitation, and is licensed to practice in Oklahoma and 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 48-year-old who reported an injury on 01/19/2012 due to a slip and fall. The patient reportedly sustained an injury to his neck, shoulders, upper and lower back. The patient was conservatively treated with medications and physical therapy. The patient underwent facet block injections that provided 80% to 90% relief. The patient underwent an MRI of the thoracic spine in 01/2013 that revealed minor anterior degenerative changes but no evidence of disc protrusion. The patient underwent an MRI of the left shoulder in 01/2013 that revealed there was evidence of mechanical impingement with an intact rotator cuff. The patient underwent an MRI of the right shoulder in 01/2013 that revealed supraspinatus muscle hypertrophy with evidence of possible impingement with no rotator cuff tear identified. The patient underwent an MRI of the cervical spine in 05/2013 that revealed a disc protrusion with spinal cord contact at the C6-7 level without any other abnormalities. The patient also underwent MRIs of the right shoulder and lumbar spine that did not reveal any significant changes from the MRIs completed in 01/2013. The patient's conservative treatment for chronic pain has included physical therapy, chiropractic care, acupuncture, and injection therapy. The patient's most recent clinical examination findings included chronic pain complaints of the neck, bilateral shoulders, and low back rated at a 9/10. Physical examination of the cervical spine revealed limited range of motion secondary to pain. Physical examination of the bilateral shoulders revealed limited range of motion with a positive impingement sign and a bilateral positive empty can supraspinatus test with decreased motor strength rated at a 4/5 bilaterally. Physical findings of the lumbar spine revealed limited range of motion with a positive Kemp's test and a positive straight leg raising test bilaterally. The patient's diagnoses included cervical vertebrae fracture, C6-7 disc protrusion, bilateral rotator cuff syndrome, lumbar vertebrae fracture, and L5-S1 disc protrusion.

The patient's treatment plan included medication refills, consultation with a neurosurgeon, and MRA of the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole, twice per day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI (gastrointestin.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI (gastrointestinal) Symptoms & Cardiovascular.

Decision rationale: The clinical documentation submitted for review does indicate that the patient has been on medications for an extended duration of time. The California Medical Treatment and Utilization Schedule recommends gastrointestinal protectants for patients who are at risk for developing gastrointestinal disturbances related to chronic medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support that the patient is at risk for developing gastrointestinal disturbances related to medication usage. Therefore, the need for a gastrointestinal protectant is not established. The request for Omeprazole, twice per day, is not medically necessary or appropriate.

Topical cream/Terocin lotion, 120 ml, applied twice per day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Topical Analgesics Page(s): 60, 111.

Decision rationale: The requested Terocin cream contains methyl salicylate, capsaicin, menthol, and lidocaine. The California Medical Treatment and Utilization Schedule does recommend the use of methyl salicylate and menthol as a topical agent for osteoarthritic pain. The clinical documentation submitted for review does provide evidence that the patient has facet degenerative changes and degenerative changes of the bilateral shoulders. Additionally, the California Medical Treatment and Utilization Schedule recommends the use of capsaicin for patients who are intolerant or unresponsive to other treatments. The clinical documentation submitted for review does provide evidence that the patient continues to have 9/10 pain in spite of medication usage. Therefore, the use of capsaicin would be indicated. However, the California Medical Treatment and Utilization Schedule states that, "No other commercially approved topical formulation of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain." As this medication contains a formulation of lidocaine that is not recommended, the medication would not be indicated. The California Medical Treatment and Utilization Schedule does not support the use of any compounded medication that contains 1

drug or drug class that is not recommended. Also, the California Medical Treatment and Utilization Schedule recommends the introduction of pain medications for the management of chronic pain be introduced 1 at a time. Therefore, a formulation of medication with multiple medications would not be indicated. The request for Topical cream/Terocin lotion, 120 ml, applied twice per day, is not medically necessary or appropriate.

Relafin: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60, 67.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. The California Medical Treatment and Utilization Schedule recommends continued use of a medication in the management of a patient's chronic pain be supported by documentation of functional benefit and a quantitative assessment of pain relief. The clinical documentation submitted for review consistently provides evidence that the patient's pain is rated at a 9/10. A quantitative assessment of pain relief related to medication usage is not provided. Additionally, the documentation submitted for review does not provide any evidence of functional benefit related to this medication. Therefore, the continued use of this medication would not be indicated. The request for Relafin is not medically necessary or appropriate.

Flexeril: Upheld

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

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

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient is being prescribed this medication to reduce symptoms of muscle spasming. However, the clinical documentation does not provide evidence that the patient has this symptom. There is no evidence of muscle spasming during the recent clinical evaluation submitted for review. Therefore, the necessity of this medication is not adequately supported. The request for Flexeril is not medically necessary or appropriate.

A neurosurgery consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 165, 180.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 305-306, 163.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has neurological deficits of the lumbar and cervical spine that have failed to respond to conservative treatments to include physical therapy, acupuncture, chiropractic care, epidural steroid injections, and facet joint injections. However, the clinical documentation submitted for review does provide evidence that the patient was recently referred to an orthopedic spine surgeon. The results of that consult were not provided for review. Therefore, the need for additional consultation cannot be determined. The American College of Occupational and Environmental Medicine recommends specialty consultations when the patient is a surgical candidate or the additional expertise of a specialized physician would contribute to treatment planning. However, as the patient has already been referred to a specialized physician, the results of that referral would need to be submitted for review to determine the need for additional consultation. The request for a neurosurgery consultation is not medically necessary or appropriate.

MRA (magnetic resonance angiography) for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

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, Arthrography Section.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient recently underwent an MRI of the shoulder. It is also noted within the documentation that the patient has chronic pain rated at a 9/10 in the bilateral shoulders that have failed to respond to conservative measures to include physical therapy, chiropractic care, acupuncture, and injection therapy. However, the Official Disability Guidelines recommend arthrography to assist in the diagnosis of labral tears. However, the clinical documentation submitted for review does not provide any evidence of instability in the shoulder to support the suspicion of a labral tear. Therefore, an MR arthrogram would not be indicated. The request for an MRA for the right shoulder is not medically necessary or appropriate.