MAXIMUS Federal Services

Case Number:	CM13-0057521		
Date Assigned:	12/30/2013	Date of Injury:	09/27/2013
Decision Date:	05/15/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	11/25/2013

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 Illinois. 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 57-year-old male who reported an injury on 09/27/2013. The mechanism of injury involved repetitive work activity. Current diagnoses include contusion, strain and sprain of the right foot and 4th toe, cervical strain and sprain, lumbosacral strain and sprain, thoracic sprain and strain, and bilateral shoulder sprain and strain. The injured worker was evaluated on 10/28/2013. The injured worker reported persistent pain over multiple areas of the body. Physical examination revealed 5/5 motor strength in bilateral upper extremities, limited range of motion of the right foot and ankle, tenderness along the spinous processes of C3 through C7, tenderness to palpation along the spinous processes of T8 through T12, tenderness along L3 through L5, positive straight leg raising, and limited range of motion of the lumbar spine. Treatment recommendations at that time included authorization for chiropractic treatment twice per week for 4 weeks, an interferential unit, a heating pad, x-rays of the cervical spine, thoracic spine, lumbar spine, and bilateral shoulders, and a MRI scan of the cervical spine, lumbar spine, and bilateral shoulders.

IMR ISSUES, DECISIONS AND RATIONALES

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

OSTEOPATHIC/CHIROPRACTIC THERAPY 2X4 FOR CERVICAL SPINE, LUMBAR SPINE AND BILATERAL SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints

Page(s): 178,207-209,303-305,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG neck, shoulder, lumbar spine & amp; pain/formulary chapters + ODG/pain/formulary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the spine is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. Treatment for the upper extremity is not recommended. The current request for chiropractic therapy twice per week for 4 weeks exceeds guideline recommendations. As such, the request is non-certified.

INFERENTIAL UNIT: Upheld

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

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, history of substance abuse, or significant pain from postoperative conditions. The injured worker does not meet any of the above mentioned criteria. There is also no evidence of a failure to respond to conservative measures. Guidelines further state, if the device is to be used, a 1 month trial should be initiated. There is no total duration of treatment specified in the request. Therefore, the request is non-certified.

MRI OF THE CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding the next steps, including the selection of an imaging test to define a potential cause. As per the documentation submitted, the injured worker demonstrated intact sensation in bilateral upper extremities with 5/5 motor strength. There is no documentation of a significant musculoskeletal or neurological deficit with regard to the cervical spine. The medical necessity has not been established. Therefore, the request is non-certified.

MRI OF THE LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG/Lumbar Spine

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: California MTUS Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause. As per the documentation submitted, there was no evidence of a musculoskeletal or neurological deficit with regard to the lumbar spine. The medical necessity for the requested imaging study has not been established. As such, the request is non-certified.

MRI BILATERAL SHOULDERS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: California MTUS/ACOEM Practice Guidelines state primary criteria for ordering imaging studies includes the emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program, or for clarification of the anatomy prior to an invasive procedure. As per the documentation submitted, there is no evidence of a significant musculoskeletal or neurological deficit with regard to bilateral shoulders. The injured worker demonstrated 5/5 motor strength in bilateral upper extremities with intact sensation. The medical necessity has not been established. Therefore, the request is non-certified.

HEATING PAD: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (Nadler-Spine, 2002) (Nadler, 2003) (Lurie-Luke 2003) (Berliner, 2004) (Lloyd, 2004).

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

Decision rationale: California MTUS/ACOEM Practice Guidelines state at-home local applications of heat or cold are as effective as those performed by therapists. There is no mention of a contraindication to at-home local applications of heat packs as opposed to a heating pad. The medical necessity has not been established. Therefore, the request is non-certified.

NAPROXEN 550MG, ONE TABLET TWICE A DAY AS NEEDED: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) lumbar spine

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

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second-line option after acetaminophen. There is no quantity listed in the current request. Therefore, the request is non-certified.

TRAMADOL ER, 150MG, ONE TABLET A DAY AS NEEDED FOR SEVERE PAIN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (UltramÂ®). Page(s): 119.

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

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. As per the documentation submitted, there is no indication that this patient has failed to respond to non-opioid analgesics. There is also no quantity listed in the current request. Therefore, the request is non-certified.

OMEPRAZOLE 20MG ONE TABLET TWICE DAILY: 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: 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 quantity listed in the current request. Therefore, the request is non-certified.

CYCLOBENZAPRINE 7.5MG ONE TABLET TWICE A DAY AS NEEDED: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain Page(s): 67. Decision based on Non-MTUS Citation ODG-Pain Chapter

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. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. There is no quantity listed in the current request. Therefore, the request is non-certified.

FLURBIPROFEN/CAPSAICIN/MENTHOL/CAMPHOR (10/0.025/2/1%) 120GM TO BE APPLIED TOPICALLY TWO TIMES EVERY MORNING AS NEEDED FOR PAIN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 117-119. Decision based on Non-MTUS Citation ODG/Pain chapter.

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 controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended, is not recommended as a whole. The only FDA-approved topical NSAID is Diclofenac. Therefore, the current request is not medically appropriate. As such, the request is non-certified.

KETOPROFEN/CYCLOBENZAPRINE/LIDOCAINE (10%/3%/5%) 120GM TO BE APPLIED TOPICALLY TWO TIMES EVERY EVENING AS NEEDED FOR PAIN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 117-119. Decision based on Non-MTUS Citation ODG/Pain chapter.

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 controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended, is not recommended as a whole. Cyclobenzaprine is not recommended as there is no evidence for the use of a muscle relaxant as a topical product. Therefore, the request is not medically appropriate. As such, the request is non-certified.