MAXIMUS Federal Services

Case Number:	CM13-0061905		
Date Assigned:	12/30/2013	Date of Injury:	05/14/2013
Decision Date:	06/11/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/05/2013

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 California. 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 38 year old female injured on 5/14/13 when she slipped and caught herself on stair railing resulting in immediate right shoulder, right scapular area, and lower back pain. The patient has a previous history of lumbar discectomy and peptic ulcer disease. Her diagnoses include cervical spine sprain/strain, right shoulder impingement, right AC cartilage disorder, radiculopathy, subacromial/subdeltoid bursitis, lumbar spine sprain/strain, right bicipital tendonitis, and LS radiculopathy. Clinical notes indicate an initial improvement in lower back pain followed by increase in right-sided cervical pain with radiation into the right scapula with intermittent numbness of the hand. The patient was referred for physical therapy, and treated with Flexeril, and Vicodin. Clinical note dated 06/18/13 indicates the patient complaining of continued cervical pain with radiation to the shoulder blade, rib area, and inferior aspect of the chest wall. She continues to deny symptoms associated with low back or lower extremities. The note dated 07/18/13 indicated the patient complaining of upper and lower back pain following extra shift at work without radiation to lower extremities. The documentation indicates the patient reported progression of lower back pain to entire back with radiation to right lower extremity. Patient underwent cervical epidural steroid injection on 09/23/13 with complete resolution of radicular symptoms for approximately one week. Clinical note dated 11/20/13 indicated the patient complained of shoulder pain, lower back pain with radiation to the right leg and groin, and cervical pain. On physical exam the right shoulder had a positive Neer's sign 90 degrees cross over. Lumbar spine flexion was 10 degrees/90 degrees. Extension was 0 degrees/25 degrees. Bilateral flexion was 5 degrees/25 degrees. She was unable to toe heel walk as all motions caused severe muscle spasm.

IMR ISSUES, DECISIONS AND RATIONALES

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

OMEPRAZOLE 20 MG # 30 WITH 1 REFILL, QUANTITY30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22,66.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, PROTON PUMP INHIBITORS.

Decision rationale: As noted in the Official Disability Guidelines, proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. Risk factors for gastrointestinal events include age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is an indication that the patient is at risk for gastrointestinal events requiring the use of proton pump inhibitors. The clinical documentation indicates the patient has a history of peptic ulcer disease and will require additional gastric protection during medical therapy with any non-steroidal anti-inflammatory medication. The medical necessity for the requested item has been established. The requested item is medically necessary.

SOMA 350 MG #60 WITH 1 REFILL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 65.

Decision rationale: As noted on page 65 of the Chronic Pain Medical Treatment Guidelines, Soma is not recommended for long-term use. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. The documentation indicates that the patient is being prescribed the medication for chronic pain and long-term care exceeding the recommended treatment window. The medical necessity for the requested item has not been established. The requested item is not medically necessary.

TRAMADOL 150 MG #180 WITH 1 REFILL: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, OPIOIDS, Page(s): 77.

Decision rationale: As noted in the documentation, previous attempts to provide pain relief with Vicodin, Flexeril, and Motrin have been unsuccessful. Per California MTUS, Ultram (Tramadol) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last asessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Medical necessity for the requested item has been established. The requested item is medically necessary.

LAB TEST CRP: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: MEDSCAPE INTERNAL MEDICINE 2013: CRP LAB TEST.

Decision rationale: CRP is used mainly as a marker of inflammation. Apart from liver failure, there are few known factors that interfere with CRP production. Measuring and charting CRP values can prove useful in determining disease progress or the effectiveness of treatments. There is no indication of any active inflammatory process related to the claimant's work related injuries. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

MRI OF LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, MRIs are the test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, they not recommended until after at least one month conservative therapy, sooner if there is a severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). There is no indication in the documentation provided that the patient has radicular symptomatology. The patient reports pain in the right lower extremity and groin; however, there was no additional significant radicular pathology noted. As such, the request for MRI of the lumbar spine cannot be recommended as medically necessary at this time.

MRI OF RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 557-559.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: As noted in the California Guidelines, routine MRI for evaluation of shoulder disorders without surgical indications is not indicated. There is no indication in the documentation that the patient has undergone conservative care to address the shoulder complaints or exhibits specific shoulder complaints to indicate rotator cuff involvement. There is no indication for surgery. As such, the request for MRI of the right shoulder is not recommended as medically necessary. Medical necessity for the requested item has not been established.

LUMBAR SPINE X-RAYS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES , LOW BACK COMPLAINTS, X-RAYS (ROENTGENOGRAMS).

Decision rationale: As noted in current guidelines, X-ray is recommended for acute low back pain with red flags for fracture or serious systemic illness, subacute low back pain that is not improving, or chronic low back pain as an option to rule out other possible conditions. The patient has currently complained of low back pain that has not improved with medication management for greater than 6 months. The claimant has a history of lumbar sprain/strain with radiculopathy. There is no specific indication for the requested lumbar spine x-rays. There is no specific indication that the x-ray results would change the present treatment plan. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

RIGHT SHOULDER X-RAYS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 15 Stress Related Conditions.

Decision rationale: As noted in the California Guidelines, X-rays of the shoulder are not recommended before 4-6 weeks of conservative therapy. There is no indication that the patient has recently undergone conservative therapy, minus medication management, for her complaints of shoulder pain. The claimant has a known diagnosis of right shoulder impingement. There is no specific indication for x-rays of the right shoulder at this time. There is no indication that x-ray results would change the current treatment plan. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

EMG/NCV OF LEFT LOWER EXTREMITY: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: As noted in the American College of Occupational and Environmental Medicine guidelines, electrodiagnostic studies are not recommended for patients with acute, subacute, or chronic back pain who do not have significant lower extremity pain or numbness. The clinical documentation indicates the patient complains of pain radiating to the right lower extremity and groin; however there is no indication of significant radicular pathology associated with the left lower extremity. Medical necessity for the requested item has not been established. the requested item is not medically necessary.

NCV OF RIGHT LOWER EXTREMITY: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: As noted in the American College of Occupational and Environmental Medicine guidelines, electrodiagnostic studies are recommended for patients with acute, subacute, or chronic back pain who have significant lower extremity pain or numbness. The clinical documentation indicates the patient complains of pain radiating to the right lower extremity and groin. The requested NCV study is medically necessary and indicated. Medical necessity for the requested item has been established.

ACUPUNCTURE TWICE A WEEK FOR FOR SIX WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: As noted in the Acupuncture Medical Treatment Guidelines, the frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed 1 to 3 times per week with an optimum duration over 1 to 2 months. Guidelines indicate that the expected time to produce functional improvement is 3 to 6 treatments. Acupuncture treatments may be extended if functional improvement is documented. The request submitted does not specify the area of the body to be addressed. Additionally, acupuncture is to be utilized in conjunction with physical therapy or to hasten rehabilitation. As such, the request for acupuncture twice a week for for six weeks cannot be recommended as medically necessary.

AQUA THERAPY TWICE A WEEK FOR SIX WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 AQUATIC THERAPY Page(s): 22.

Decision rationale: As noted on page 22 of the Chronic Pain Medical Treatment Guidelines, aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. There is no indication in the medical records that the patient requires aqua therapy due to physical disability or severe obesity. As such, the request for aqua therapy twice a week for six weeks cannot be recommended as medically necessary.

LAB TESTS- ARTHRITIS PANEL: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back - Lumbar & Thoracic (Acute & Chronic), Preoperative Testing, General.

Decision rationale: As noted in the Official Disability Guidelines, it is unclear whether the benefits accrued from responses to true-positive tests outweigh the harms of false-positive preoperative tests and, if there is a net benefit, how this benefit compares to the resource utilization required for testing. There is no indications in the patient's documentation that would necessitate obtaining a arthritis panel on a 38 year old female at this point in the patient's treatment plan. As such, the request for arthritis panel cannot be recommended as medically necessary at this time.