

Case Number:	CM13-0068472		
Date Assigned:	01/03/2014	Date of Injury:	02/20/2006
Decision Date:	10/09/2014	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	12/19/2013

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 & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 56 year old female who reported an injury on 02/20/2006. The injured worker had a diagnosis of bilateral sacroilitis left worse than right. The past medical treatment included medications, physical therapy, acupuncture, chiropractic therapy, lumbar spine injection, and injections to the left sacroiliac joint on 06/24/2008 and 03/19/2009. Diagnostic testing included an MRI of the lumbar spine the date of which was not provided and an x-ray of lumbar spine. There was no pertinent surgical history. The injured worker complained of constant pain in the lower back described as dull throbbing on 10/09/2013. The injured worker stated the pain occurred mostly when standing in one place for 3-5 minutes, and indicated it radiated to both legs accompanied with numbness and tingling occasionally down to feet. The injured worker rated the pain at 10/10 at times, in addition she felt weakness to the lower extremities on the left side and she feared falling down. The physical examination revealed bilateral parspinal tenderness to the area of the sacroiliac join, more so on the left than the right. The range of motion of lumbar spine showed forward flexion at 45 degrees and extension at 30 degrees. Medications included Norco. The treatment plan was for Prilosec 20mg capsules quantity 60 and Naprosyn 15% compound cream 240grams quantity 1.00. The rationale for the request was not submitted. The request for authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRILOSEC 20 MG CAPSULES: QUANTITY 60.00: Upheld

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

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

Decision rationale: The request for prilosec 20 mg capsules: quantity 60.00 is not medically necessary. The injured worker complained of constant pain in the lower back described as dull throbbing pain on 10/09/2013. The California MTUS guidelines recommend the use of a proton pump inhibitor for injured workers at intermediate risk for gastrointestinal events with no cardiovascular disease and injured workers at high risk for gastrointestinal events with no cardiovascular disease. The guidelines note injured workers at risk for gastrointestinal events include injured workers over 65 years of age, injured workers with a history of peptic ulcer, GI bleeding or perforation, with concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no evidence of a history of gastrointestinal bleeding, perforation, or peptic ulcer. There is no evidence that the injured worker reported gastrointestinal symptoms. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore the request is not medically necessary.

NAPROSYN 15% COMPOUND CREAM 240 GRAMS QUANTITY 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 28-29, 112-113.

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

Decision rationale: The request for Naprosyn 15% compound cream 240 grams quantity 1.00 is not medically necessary. The injured worker complained of constant pain in the lower back described as dull throbbing pain on 10/09/2013. The request for The California (MTUS) Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy and safety. The guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder and use with neuropathic pain is not recommended as there is no evidence to support use. There is a lack of documentation indicating the injured worker has been treated with first line therapy. There is no indication that the injured worker has a diagnosis of osteoarthritis or tendinitis to a joint amenable to topical treatment. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication. Given the above, the request is not medically necessary.

COMPUTERIZED RANGE OF MOTION TESTING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines AMA Guides to Evaluation of Permanent Impairment, 5th Edition

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Flexibility.

Decision rationale: The request for Computerized Range of Motion Testing is not medically necessary. The injured worker complained of constant pain in the lower back described as dull throbbing pain on 10/09/2013. The Official Disability Guidelines (ODG) state range of motion testing is not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. In addition the guidelines do not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. The guideline also states measurement of three dimensional real time lumbar spine motion including derivatives of velocity and acceleration has greater utility in detecting patients with low back disorder than range of motion. The range of motion of lumbar spine showed forward flexion at 45 degrees and extension at 30 degrees. There was a lack of documentation stating there was any unclear therapeutic value in the measures of the lumbar spine range of motion provided within documentation. There is no indication that the injured worker's range of motion could not be assessed with an inclinometer. Additionally, the guidelines do not recommend the use of computerized range of motion testing. Therefore the request for computerized range of motion test is not medically necessary.