

Case Number:	CM14-0002704		
Date Assigned:	01/29/2014	Date of Injury:	09/11/2009
Decision Date:	06/16/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	01/07/2014

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 Anesthesiology, has a subspecialty in Pain Management 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 has filed a claim for cervical radiculopathy associated with an industrial injury date of September 11, 2009. The treatment to date has included acupuncture, medications, interferential (IF) unit, and physical therapy. The medical records from 2013 through 2014 were reviewed showing the patient complaining of chronic neck pain with radiation to the upper extremities bilaterally. The pain is rated at 8/10 with medications and 10/10 without medications. The pain is exacerbated by activity and walking. The patient has limitations in activities of daily living, such as self care and hygiene, ambulation, hand functions, sleep and sex. On examination, the cervical spine musculature was noted to have spasms. There was tenderness over the spinal vertebrae and paracervical area. The range of motion was noted to be limited due to pain. There was decreased strength bilaterally. The patient currently takes Norco, Gabapentin, and Butrans for pain. The patient was diagnosed with gastroesophageal reflux disease (GERD) by a gastroenterologist in September 2013. The utilization review from December 10, 2013, denied the requests for prilosec, due to no gastrointestinal (GI) risk factors; the interferential unit, due to no functional benefits from continued use; and the lumbar support, due to no evidence of instability or post op treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRILOSEC 20 MG QTY:60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS, AND CARDIOVASCULAR RISK Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS, AND CARDIOVASCULAR RISK, Page(s): 68.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicate that proton pump inhibitors are recommended for patients who are at high risk for gastrointestinal events. In this case, the patient has been diagnosed with gastroesophageal reflux disease (GERD) from a gastroenterology consult in September 2013. The patient is on multiple medications. The criteria for this medication have been met. Therefore, the request for Prilosec 20mg is medically necessary.

CONTINUE INTERFERENTIAL UNIT QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS), Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS), Page(s): 118-120.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicate that interferential units are not recommended as the primary treatment modality, but a one-month trial may be considered if used as an adjunct to a program of evidence-based functional restoration given that conservative treatment methods have failed to evaluate the benefits of the device. In this case, the patient has been using the interferential unit, but the documentation does not provide evidence of functional benefits derived from the use of this device. The duration and frequency of use was not stated neither was the effect on the usage of medications. Therefore, the request for interferential unit is not medically necessary.

RETRO 11/14/13 LUMBAR SUPPORT DISPENSED QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS ACOEM, OCCUPATIONAL MEDICAL PRACTICE GUIDELINES, 2ND EDITION, LOW BACK PAIN, UPDATE 2008, CHAPTER 12, PAGE 138-139, LUMBAR SUPPORTS.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: The MTUS/ACOEM Guidelines indicate that lumbar supports have not been shown to have any lasting benefits beyond the acute phase of symptom relief. In this case, the patient was not documented to have any acute low back pain. The main concern is the patient's neck for which a brace is being used. Given no indication for the lumbar support, the request for lumbar support was not medically necessary.