

Case Number:	CM14-0178832		
Date Assigned:	11/03/2014	Date of Injury:	04/25/2007
Decision Date:	12/08/2014	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	10/28/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine, 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 43 years old male with an injury date on 04/25/2007. Based on the 05/22/2014 progress report provided by [REDACTED], the diagnoses are: 1.Cervical spine disc degenerative disease at C5-C6 level with 2-2.5 mm posterior disc protrusion centrally resulting in mild effacement of the ventral subarachnoid space, 2.Left greater occipital nerve irritation.3. Cervical spine sprain/strain, 4.Right shoulder pain secondary to rotator cuff impingement syndrome status post right shoulder endoscopic surgery more than one year ago, 5.Low back pain status post lumbar spine surgery on 03/14/2012. Now the patient complaints of low back pain, which is located in his bilateral lumbosacral area.According to this report, the patient complains of "neck pain, which radiates to his bilateral upper shoulder arms. The patient reports his pain, has been getting worse since last month. The patient continues to complaint of low back pain." Objective findings indicate tenderness at the paracervical and paralumbar muscles, weakness of the right deltoid muscle, decreased left patellar reflex, decrease sensation in the direction of left L4, L5 and S1, positive left straight leg raise and Spurling's test, head compression cause discomfort, and decreased lumbar range of motion. The 04/25/2014 report indicates the patient has low back pain at 8/10 with numbness and tingling that radiates to the bilateral legs. There were no other significant findings noted on this report. The utilization review denied the request on 10/08/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 03/27/2014 to 05/22/2014

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46-47.

Decision rationale: According to the 05/22/2014 report by [REDACTED] this patient presents with neck pain, which radiates to the bilateral upper extremity and low back pain that radiates to the bilateral legs. The treater is requesting Lumbar epidural steroid injection. The most recent progress report is dated 05/22/2014 and the utilization review letter in question is from 10/08/2014. Regarding ESI, MTUS guidelines states "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." Review of reports does not show any evidence of prior epidural steroid injections. While this patient presents with radiating pain down the both legs, they are not described in specific dermatomal distribution to denote radiculopathy or nerve root pain. Furthermore, the treater does not discuss MRI or other imaging studies that would corroborate the patient's leg symptoms. Without imaging study corroboration, radiculopathy cannot be verified. The request is not medically necessary.

Motorized cold therapy unit for purchase only: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg Chapter, continuous-flow cryotherapy section

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) continuous-flow cryotherapy under shoulder

Decision rationale: According to the 05/22/2014 report by [REDACTED] this patient presents with neck pain, which radiates to the bilateral upper extremity and low back pain that radiates to the bilateral legs. The treater is requesting motorized cold therapy unit for purchase only. Regarding cold therapy, ODG guidelines "recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." Review of reports does not show the patient is scheduled for any surgery; therefore, the request is not medically necessary.

Tizanidine 4mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS Page(s): 66.

Decision rationale: According to the 05/22/2014 report by [REDACTED] this patient presents with neck pain, which radiates to the bilateral upper extremity and low back pain that radiates to the bilateral legs. The treater is requesting Tizanidine 4mg quantity 60. Tizanidine a muscle relaxant was first noted in the 03/27/14 report. The MTUS guidelines page 66, "Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain."In this case, given the patient's chronic pain, use of this medication may be indicated. However, the treater does not explain how this medication is being used with what effectiveness. The MTUS guidelines page 60 require documentation of medication efficacy when it is used for chronic pain. The request is not medically necessary.

Omeprazole 20 mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPI: NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: According to the 05/22/2014 report by [REDACTED] this patient presents with neck pain, which radiates to the bilateral upper extremity and low back pain that radiates to the bilateral legs. The treater is requesting Omeprazole 20mg quantity 60. Omeprazole was first mentioned in the 03/27/14 report; it is unknown exactly when the patient initially started taking this medication. The MTUS Guidelines state Omeprazole is recommended for patients at risk for gastrointestinal events if used prophylactically for concurrent NSAIDs. MTUS requires proper GI assessment such as the age, concurrent use of anticoagulants, ASA, history of PUD, gastritis, etc. Review of report do not show that the patient has gastrointestinal side effects with medication use. Patient is currently not on NSAID. There is no discussion regarding GI assessment as required by MTUS. MTUS does not recommend routine use of GI prophylaxis without documentation of GI risk. In addition, the treater does not mention symptoms of gastritis, reflux or other condition that would require a PPI. The request is not medically necessary.