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| Case Number: | CM14-0034795 | | |
| Date Assigned: | 06/20/2014 | Date of Injury: | 06/21/2006 |
| Decision Date: | 07/24/2014 | UR Denial Date: | 03/14/2014 |
| Priority: | Standard | Application Received: | 03/20/2014 |

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 and is licensed to practice in California and Nevada. 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 male who had work related injury on 06/21/06. Mechanism of injury was not documented. His diagnosis was degenerative disc disease, cervical spine, chronic lumbar pain, bilateral shoulder rotator cuff tendinopathy and bilateral shoulder rotator cuff tear. The injured worker was treated conservatively to date with medication and physical therapy x 24 visits. Diagnostic studies to date including magnetic resonance imaging. Physical examination dated 05/27/14 lumbar spine revealed tenderness to palpation over paraspinals. There was tenderness to palpation over the paraspinous musculature; there was no point tenderness to palpation on the spinous process. There was mild tenderness over sacroiliac joints bilaterally. Distally there were no gross motor deficits. Shoulder examination demonstrated range of motion of 140 degrees of abduction, 120 degrees of forward flexion. He had mild tenderness to palpation over subacromial arch bilaterally, more significant to the right than the left. He had mild pain with impingement type maneuvers. There was no documentation of visual analog scale (VAS) scores, pain reduction, functional improvement. Request was for Norco 5/325 #400, physical therapy 3x4, Motrin 800mg #90 and X-ray lumbar spine obtained on 03/06/14. Prior utilization review on 03/13/14 non-certified physical therapy, Motrin, and x-ray of lumbar spine and modified Norco 5/325.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #400: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids.

Decision rationale: The request for Norco 5/325 #400 is not medically necessary. The clinical documentation submitted and current evidence based guidelines do not support the request for Norco 5/325. There was no documentation of visual analog scale (VAS) scores, pain reduction and functional improvement. As such, medical necessity has not been established.

Physical Therapy 3x4: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Physical Medicine Treatment.

Decision rationale: The request for physical therapy 3x4 is not medically necessary. The clinical documentation submitted for review and current evidence based guidelines do not support the request for physical therapy. The injured worker has already completed 24 visits of physical therapy, and there is no documentation of a recent event that had caused an increase in his symptoms. Therefore medical necessity has not been established.

Motrin 800mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, NSAID's.

Decision rationale: The request for Motrin 800mg #90 is not medically necessary. The clinical documentation does not support the request for Motrin 800mg. Motrin is recommended for short term use in acute exacerbation of chronic low back pain. Not to be used long term. There is no documentation of functional improvement or decrease in pain. Therefore, medical necessity has not been established.

X-Ray Of Lumbar Spine- Obtained 3/6/14: Upheld

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

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, Radiography (x-rays).

Decision rationale: The request for X-ray lumbar spine obtained on 03/06/14 is not medically necessary. The clinical documentation submitted for review and current evidence based guidelines do not support the request. Lumbar spine radiography should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. No documentation of a recent event that caused an increase in his symptoms. Therefore medical necessity has not been established.