

Case Number:	CM14-0071517		
Date Assigned:	08/06/2014	Date of Injury:	02/14/2014
Decision Date:	09/22/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	05/16/2014

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 Medicine and is licensed to practice in Florida. 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 40-year-old male who reported an injury on 02/14/2014. The mechanism of injury was not provided for clinical review. The diagnoses included lumbar sprain and shoulder sprain. Previous treatments included medication. Within the clinical note dated 04/15/2014, the clinical note was largely illegible. Within the most recent note dated 05/29/2014, it was reported the injured worker complained of low back pain rated 6/10 in severity. He complained of left shoulder pain rated 6/10 in severity. The injured worker complained of right shoulder pain rated 4/10 to 5/10 in severity. Upon the physical examination, the provider noted the injured worker had tenderness to the lumbar, left greater than right. The provider noted the injured worker had paresthesia to the left L3 dermatome. The provider noted tenderness to the bilateral shoulders. The request submitted was for follow-up in 4 weeks, topical compound cream, cyclobenzaprine, pantoprazole, naproxen, motorized cold therapy, interferential unit, functional capacity evaluation, urinalysis for toxicology, and chiropractic sessions. However, a rationale was not provided for clinical review. The Request for Authorization was submitted on 04/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow up in 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: The California MTUS/ACOEM Guidelines state physician follow-ups can occur when released to modified, increased, or full duty is needed, or after appreciable healing or recovery can be expected on average. There is a lack of documentation of an adequate physical examination. The request submitted failed to provide the type of follow-up that was requested. There was a lack of documentation indicating the injured worker had a release to modified, increased, or full duty. Therefore, the request for a follow-up in 4 weeks is not medically necessary.

Topical compound creams (unspecified names, dose, and quantity): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic's Page(s): 111.

Decision rationale: The California MTUS Guidelines note topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines note any compounded product that contains at least 1 drug that is not recommended is not recommended. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the medication's name, dose, quantity, and frequency. Therefore, the request for topical compound creams is not medically necessary.

Cyclobenzaprine 7.5mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page(s): 63 , 64.

Decision rationale: The California MTUS Guidelines recommend no sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication since at least 04/2014, which exceeds the guideline recommendation of short-term use of 2 to 3 weeks. Therefore, the request for cyclobenzaprine 7.5mg #90 is not medically necessary.

Pantoprazole20mg #60: Upheld

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

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

Decision rationale: The California MTUS Guidelines note proton pump inhibitors such as pantoprazole are recommended for injured workers who are at risk for gastrointestinal events and/or cardiovascular disease. Risk factors for gastrointestinal events include over the age of 65, history of peptic ulcer, gastrointestinal bleed or perforation, use of corticosteroids and/or anticoagulants. In the absence of risk factors for gastrointestinal events, proton pump inhibitors are not indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes stopping the NSAID, switching to a different NSAID, or adding an H2 receptor antagonist or proton pump inhibitor. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, there is a lack of clinical documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. Therefore, the request for Pantoprazole 20mg #60 is not medically necessary.

Naproxen550mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen, NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 66, 67.

Decision rationale: The California MTUS Guidelines not naproxen is a non-steroidal anti-inflammatory drug for the relief of the signs and symptoms of osteoarthritis. The guidelines recommend naproxen at the lowest dose for the shortest period of time in patients with moderate to severe pain. There is a lack of documentation indicating the medication had been providing objective functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request for Naproxen 550mg #90 is not medically necessary.

Motorized Cold Therapy: 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 (ODG) Shoulder, Continuous-flow cryotherapy.

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be

up to 7 days, including home use. In the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, and swelling, and narcotic usage. However, the effect on more frequently treated acute injuries including muscle strains and contusions have not been fully evaluated. Continuous flow cryotherapy units provide regulated temperature through the use of power to circulate ice water in the cooling packs. There is lack of documentation indicating the provider intended the injured worker to undergo surgery. The treatment site is not provided for clinical review. Therefore, the request for motorized cold therapy is not medically necessary.

Interferential Units: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Page(s): 118-119.

Decision rationale: The California MTUS Guidelines do not recommend a stim care unit as an isolated intervention. There is no quality evidence of effectiveness, except in conjunction with recommended treatments including return to work, exercise, and medications, and limited evidence of improvement on those recommended treatments alone. It may possibly be appropriate for the following conditions if documented, that pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, and there is a history of substance abuse, significant pain from postoperative conditions which limit the ability to perform exercise programs/physical therapy treatment, or unresponsiveness to conservative measures. There is a lack of evidence in the documentation provided that would reflect diminished effectiveness of medications, a history of substance abuse, or any postoperative conditions which would limit the injured worker's ability to perform exercise programs/physical therapy treatment. There is a lack of documentation indicating the injured worker was unresponsive to conservative measures. The requesting physician did not include an adequate and complete assessment of the injured worker's objective functional condition which would demonstrate deficits needing to be addressed as well as establish a baseline by which to assess objective functional improvement over the course of therapy. The request for an interferential unit is not medically necessary.

Functional Capacity Evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89. Decision based on Non-MTUS Citation (ODG) Fitness For Duty, Functional Capacity Evaluation.

Decision rationale: The California MTUS/ACOEM Guidelines state that it may be necessary to obtain a more precise delineation of patients' capabilities than is available from routine physical

examination, under some circumstances, this can be done by ordering a functional capacity evaluation of the injured worker. In addition, the Official Disability Guidelines recommend a functional capacity evaluation may be used prior to admission to a work hardening program with preferences for assessment tailored to a specific task or job. The functional capacity evaluation is not recommended as a routine use, as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. There is a lack of documentation as to how the functional capacity evaluation will aid the provider in the injured worker's treatment plan and goal. There is a lack of documentation upon the physical examination and lack of documentation of other treatments the injured worker has undergone previously and the measurements of the progress with the prior treatments. The provider's rationale was not provided for clinical review. There is a significant lack of neurological deficit such as decreased sensation or motor strength. There is a lack of documentation indicating the provider requested a work hardening program as well. The request for a functional capacity evaluation is not medically necessary.

Urinalysis for toxicology: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Test Page(s): 43.

Decision rationale: The California MTUS Guidelines recommend a urine drug test as an option to assess for the use or the presence of illegal drugs. It may be also used in conjunction with a therapeutic trial of opioids for ongoing management and as a screening for risk of misuse and addiction. The documentation provided did not indicate the injured worker displayed any aberrant drug-seeking behaviors, or whether the injured worker was suspected of illegal drug use. While a urine drug screen would be appropriate for individuals on opioids, a urine drug screen after the initial baseline would not be recommended unless there is significant documentation of aberrant drug-seeking behaviors. There is a lack of documentation indicating the injured worker's current medication regimen. The request for a urinalysis for toxicology is not medically necessary.

Chiropractic 3 times a week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: The California MTUS Guidelines recommend manual therapy for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of manual therapy is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to

productive activities. The guidelines recommend a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement, a total of 18 visits over 6 to 8 weeks. There is a lack of documentation regarding a complete physical examination to evaluate for decreased functional ability, decreased range of motion, and decreased strength and flexibility. The number of sessions requested exceeds the guideline recommendations of a trial of 6 visits over 2 weeks. The request for chiropractic sessions 3 times a week for 4 weeks is not medically necessary.