

Case Number:	CM14-0086670		
Date Assigned:	08/08/2014	Date of Injury:	10/15/2013
Decision Date:	09/18/2014	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	06/09/2014

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 Texas. 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 23 year old female who had a work related injury on 10/15/13. The injured worker was a restrained driver when she was involved in a motor vehicle accident, as she was coming from the bank after making a deposit of the restaurant's cash as instructed by her manager. The injured worker indicates that there was traffic heading the opposite way and the cars on the first 2 lanes, let her in to make the left turn and she proceeded to turn, however, she failed to see another car at the 3rd lane which was traveling fast and collided against the middle and front side of her vehicle. The airbags in her vehicle did not deploy and she lost consciousness for about 1 minute. The injured worker states that she noticed an immediate onset of pain in her neck, arms, chest, back, and left ankle and leg. The injured worker was transported to Northridge Hospital by her sister where she was only evaluated and provided with a cervical collar and medications and discharged an hour later. The injured worker had a magnetic resonance image (MRI) of her left ankle on 05/07/14. Impression was posterior tibialis tenosynovitis. MRI of her brain dated 05/07/14 unremarkable enhanced intracranial magnetic resonance evaluation. Right maxillary shows acute sinusitis. MRI of her cervical spine with flexion and extension views dated 05/05/14, C6-7 1mm central disc protrusion 0mm in flexion, 1mm in extension. Postural changes were also noted. Non-specific maxillary sinus disease was present. No other abnormalities noted. MRI of thoracic spine with flexion and extension views dated 05/05/14 revealed postural changes. No other abnormality is noted. The most recent clinical documentation submitted for review is dated 06/11/14. It is a handwritten note, difficult to read but the subjective complaints were: cervical spine rated 3/10; Thoracic spine 5/10; Lumbosacral spine 5/10; Chest and ankle 0/10; Lumbosacral spine; pain was localized to the low back. Chest noticed stiffness at times. Physical examination left ankle plantar flexion is 40 degrees. Dorsal flexion is 15 degrees. There was Lumbosacral positive tenderness to palpation

over the paraspinal muscles. Diagnosis was: cervical spine sprain; Thoracic sprain; Lumbar region sprain; Ankle sprain; and unspecified injury to the head. Prior utilization review was non-certified on 06/02/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physiotherapy 2 x 4 to the neck, thoracic, lumbar, left ankle: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 4/14/14) Lumbar & Thoracic (updated 5/12/14) Ankle & Foot Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The clinical information submitted for review does not support the request. Physical examination reveals tenderness to palpation; no other objective findings were noted. As such, Physiotherapy 2 x 4 to the neck, thoracic, lumbar, left ankle is not medically necessary.

LINT to the neck, thoracic and lumbar (localized intense neurostimulation therapy): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous electrical nerve stimulation (PENS) Page(s): 97.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

Decision rationale: The clinical documentation submitted for review does not support the request. There is no clear reason, based on the clinical information submitted, for the request, or what benefit the injured worker would receive from the therapy. Therefore, LINT to the neck, thoracic and lumbar (localized intense Neurostimulation Therapy) is not medically necessary.

Internal Medicine Consult for Insomnia: 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page(s) 127.

Decision rationale: The clinical information submitted for review does not support the request. There is no documentation that the injured worker has had a trial and failure of sleep medication. As such, Internal Medicine Consult for Insomnia is not medically necessary.

Neurologist consult for the head injury: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page(s) 127.

Decision rationale: The clinical documentation submitted for review does not support the request. There is no documentation of any focal neurological abnormalities; therefore medical necessity has not been established. Therefore, Neurologist consult for the head injury is not medically necessary.

Menthoderm (Methyls salicylate 15%, menthol 10%) gel 360gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Salicylate Analgesics Page(s): 105, 111, 143.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Page(s): 105.

Decision rationale: As noted on page 105 of the Chronic Pain Medical Treatment Guidelines, salicylate topicals are recommended in the treatment of chronic pain. This compound is known to contain menthol and methyl salicylate. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. However, there is no indication in the documentation that the patient cannot utilize the readily available over-the-counter version of this medication without benefit. As such, Menthoderm (Methyls salicylate 15%, menthol 10%) gel 360gm is not medically necessary.

Hydrocodone/APAP 2.5/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 78-80, 91, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

Decision rationale: Current evidenced-based guidelines indicate patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is insufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic

medications. Documentation does not indicate a significant decrease in pain scores with the use of medications. As such, Hydrocodone/APAP 2.5/325mg #90 is not medically necessary.

Omeprazole 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - online version, Integrated Treatment/Disability Duration Guidelines, Pain (Chronic), Proton pump inhibitors (PPIs).

Decision rationale: As noted in the Official Disability Guidelines - Online version, Pain Chapter, proton pump inhibitors (PPIs) are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug (NSAID) use. Risk factors for gastrointestinal events include age > 65 years; history of peptic ulcer, gastrointestinal bleeding or perforation; concurrent use of aspirin (ASA), corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no indication that the patient is at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. As such, Omeprazole 20mg #30 is not medically necessary is not medically necessary.