MAXIMUS Federal Services

Case Number:	CM14-0092059		
Date Assigned:	07/25/2014	Date of Injury:	12/15/2011
Decision Date:	09/26/2014	UR Denial Date:	05/22/2014
Priority:	Standard	Application Received:	06/18/2014

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 Family Medicine 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 injured worker is a 56 year old female who sustained an injury on 07/31/12 due to repetitive work injuries. The injured worker reported complaints of ongoing neck back and upper extremities complaints since the date of injury. The injured worker was also involved in a motor vehicle accident which contributed to symptoms. Prior treatment included trigger point injections without benefit. The injured worker also received physical and acupuncture treatment. The injured worker was diagnosed with severe carpal tunnel symptoms severe carpal tunnel syndrome. Prior medication use included tramadol and omeprazole. The injured worker was recommended for epidural steroid injections however the lumbar spine however these did not appear to have been approved through insurance. As of 03/14 the injured worker had been recommended for anterior cervical discectomy and fusion from C4 to C7. The injured worker was seen on 04/30/14 with continuing complaints of pain and decreased range of motion in the cervical spine with facet tenderness to palpation. Physical examination noted decreased sensation in right C6 distribution with decreased range of motion and spasms in the cervical spine. There was also positive impingement signs in the right shoulder with tenderness to palpation over the right acromioclavicular joint. The injured worker was recommended to continue with medications and surgery was recommended. The requested assistant surgeon with two day ininjured worker stay Prilosec 20mg #60 Lidoderm 5% patch #30 and injection of right trapezius with steroids were denied by utilization review on 05/22/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Assistant surgeon with 2 day inpatient stay at [redacted]: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Hospitalization.Other Medical Treatment Guideline or Medical Evidence:American Association of Orthopaedics Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics.

Decision rationale: In regards to the request for assistant surgeon and two day inpatient stay the injured worker was recommended for C4 to C7 ACDF. Although these procedures would reasonably require an assistant surgery guidelines would not support two day inpatient stay given the absence of any comorbid conditions that would require this number of inpatient stay days. At most for ACDF guidelines would support one day inpatient stay for post-operative monitoring. As such this reviewer would not have recommended the proposed request as submitted as medically necessary. The request is therefore not medically necessary and appropriate.

Prilosec 20mg #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, proton pump inhibitors.

Decision rationale: In regards to the use of Prilosec 20mg quantity 60, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The clinical records provided for review did not discuss any side effects from oral medication usage including gastritis or acid reflux. There was no other documentation provided to support a diagnosis of gastroesophageal reflux disease. Given the lack of any clinical indication for the use of a proton pump inhibitor this reviewer would not have recommended this request as medically necessary. The request is therefore not medically necessary and appropriate.

Lidoderm Patch 5% #30 no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patch Page(s): 54.

Decision rationale: Based on review of the clinical documentation submitted for review the requested Lidoderm patch 5% #30 would not be supported as medically necessary. Clinical documentation submitted for review noted continued radicular findings on physical examination however the clinical documentation did not discuss prior use of first line medications for neuropathic pain such as Lidoderm such as Neurontin or Lyrica or any antidepressants. Per guidelines Lidoderm patches can be considered an option in the treatment of neuropathic pain that has failed first line medications including anticonvulsants and antidepressants. As this was not specifically noted in the clinical documentation submitted for review this reviewer would not have recommended this request as medically appropriate. The request is therefore not medically necessary and appropriate.

Right trapezius injection celestone 1cc and Marcaine 2cc: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines point injections Page(s): 122.

Decision rationale: In review of the clinical documentation submitted for review the proposed right trapezius injection with steroids and Marcaine would not be supported as medically necessary. The most recent report from 04/30/14 did not specifically discuss the rationale behind this type of injection. Physical examination findings noted pain over right shoulder at acromioclavicular joint however there did not appear to be any specific trigger points in the trapezii that would support injection therapy as requested. Therefore this request was not considered medically necessary and appropriate.