

Case Number:	CM14-0096136		
Date Assigned:	09/22/2014	Date of Injury:	10/18/2011
Decision Date:	11/05/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	06/24/2014

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 Practice and is licensed to practice in Texas and Mississippi. 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 37-year-old male who reported an injury on 10/18/2011. The mechanism of injury involved a fall. The current diagnoses include ulnar impaction syndrome of the right wrist, discogenic lumbar condition with radiculopathy, discogenic cervical condition, elements of depression and sleep disorder, elements of headaches, element of dizziness, ankle sprain, and weight gain of 50 pounds. The injured worker was evaluated on 06/04/2014 with complaints of persistent lower back pain, mid back pain, and neck pain. Previous conservative treatment is noted to include medications, occipital nerve block, and bracing. Physical examination revealed no acute distress, 20 degree cervical extension, 30 degree cervical flexion, normal range of motion of the right wrist, crepitation in the right wrist, and 20 degree lumbar extension with 55 degree flexion. Treatment recommendations at that time included an MRI of the right wrist, 12 sessions of acupuncture, a gym membership for 3 months, and continuation of the current medication regimen. A Request for Authorization form was then submitted on 06/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right wrist: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: California MTUS/ACOEM Practice Guidelines state for most patients presenting with true hand and wrist problems, special studies are not needed until after a 4 to 6 week period of conservative care and observation. It was noted in the documentation provided for review; the injured worker underwent an MRI of the right wrist in 2011. The current physical examination of the right wrist revealed normal range of motion with crepitation. There is no documentation of a progression or worsening of symptoms or physical examination findings that would warrant the need for a repeat imaging study. The medical necessity has not been established. Therefore, the request MRI of the right wrist is not medically necessary and appropriate.

Twelve (12) Acupuncture sessions for the low back: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated and may be used as an adjunct to physical rehabilitation and/or surgical intervention. The time to produce functional improvement includes 3 to 6 treatments. The current request for 12 sessions of acupuncture exceeds guideline recommendations. Therefore, the request of twelve (12) Acupuncture sessions for the low back is not medically necessary and appropriate.

Gym Membership for 3 months for the cervical and lumbar Spine: 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 Official Disability Guidelines (ODG) Knee & Leg Chapter, Gym membership

Decision rationale: The Official Disability Guidelines state gym memberships are not recommended as a medical prescription unless a home exercise program has not been effective and there is a need for equipment. There is no indication that the injured worker has failed to respond to a home exercise program. There is also no indication that the injured worker requires specialized equipment. As such, the request of Gym Membership for 3 months for the cervical and lumbar Spine is not medically necessary and appropriate.

Pain Management Consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Evaluation & Management, Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. There was no documentation of a significant musculoskeletal or neurological deficit upon physical examination. There is no evidence of a significant functional limitation. There is no clear documentation of an exhaustion of diagnostic and therapeutic management. The medical necessity for the requested consultation has not been established at this time. Therefore, the request for Pain Management Consultation is not medically necessary and appropriate.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the injured worker has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized this medication since 08/2013 without any evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request of Tramadol ER 150mg #30 is not medically necessary and appropriate.

Topamax 50mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22.

Decision rationale: California MTUS Guidelines state Topamax has been shown to have variable efficacy, with a failure to demonstrate efficacy in neuropathic pain of central etiology. Topamax is considered for use for neuropathic pain when other anticonvulsants have failed. There is no documentation of a failure to respond to first line anticonvulsants. There is also no frequency listed in the request. As such, the request Topamax 50mg #60 is not medically necessary and appropriate.

Protonix 20mg #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 Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factors and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. Therefore, the injured worker does not meet criteria for the requested medication. As such, the request of Protonix 20mg #60 is not medically necessary and appropriate.

Norco 10/325mg #120: 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 Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized this medication since 08/2013 without any evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request of Norco 10/325mg #120 is not medically necessary and appropriate.