

Case Number:	CM14-0181935		
Date Assigned:	11/06/2014	Date of Injury:	04/25/2007
Decision Date:	02/03/2015	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	11/03/2014

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 Physical Medicine Rehab 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 43-year-old male who reported an injury on 04/25/2007. The mechanism of injury was not submitted for this review. Prior treatment included medications and MRI studies. It was documented the injured worker had undergone an unofficial MRI study that revealed cervical spine 2 mm to 2.5 mm posterior disc protrusion at level of C5-6 resulting in effacement of the ventral subarachnoid space. The injured worker was evaluated on 05/22/2014 and it was documented the injured worker complained of neck pain, which radiates to his bilateral upper shoulder and arm. The injured worker reported his pain was getting worse since last month. The injured worker continues to complain of low back pain. Objective findings included paracervical muscles are tender to touch with increased tone; right deltoid muscle weakness, 4/5; bilateral paralumbar muscles are tender to touch; decrease patellar reflex on the left side compared to the right side; decreased sensation in the direction of left L4, L5 and S1; positive straight leg raise in 40 degrees on the left side; and lumbar extension causes pain over the facet joints. The injured worker reported his neck pain was worse than his lower back pain. Range of motion lumbar spine, flexion 40 degrees, extension 20 degrees, right tilt 30 degrees, left tilt 30 degrees and right/left rotation was 30 degrees. Spasm was present with lumbar spine. Spurling's test was positive in cervical spine bilaterally. Head compression causes discomfort. Diagnoses included cervical spine disc degenerative disease at C5-6 level with 2 mm to 2.5 mm posterior disc protrusion syndrome resulting in mild effacement of the ventral subarachnoid space; left greater occipital nerve irritation; cervical spine sprain/strain; right shoulder pain secondary to rotator cuff impingement syndrome status post right shoulder endoscopic surgery more than 1 year ago; and low back status postlumbar spine surgery on 03/14/2012. The injured worker complains of low back pain, which was located in his bilateral lumbosacral area. The treatment plan included lumbar epidural steroid injection and a refill on medications. Request

for Authorization dated 05/31/2014 was for lumbar epidural steroid injection and medication refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: The California MTUS Guidelines recommend ESI as an option for treatment of radicular pain. An epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is no information on improved function. The criteria for use for an ESI are: radiculopathy must be documented by physical examination and corroborated by imaging studies, be initially unresponsive to conservative treatment, injections should be performed using fluoroscopy, and no more than 2 nerve root levels should be injected using transforaminal blocks. The clinical notes lack evidence of objective findings of radiculopathy. There was no radiculopathy documented by the physical examination. There is a lack of documentation of the injured worker's initial unresponsiveness to conservative treatment, which would include exercises, physical methods, and medications. The request did not indicate the use of fluoroscopy for guidance in the request. As such, the request is not medically necessary.

Motorized cold therapy unit for purchase only: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG), Cold/heat packs.

Decision rationale: The Official Disability Guidelines state that cold/heat packs are recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. The request failed to include body location where cold therapy is required. Cold therapy local applications are recommended in the first few days of acute complaint. Documentation submitted for review indicates the injured worker's injury on 04/25/2007 would

be out of the range for acute pain. As such, the request for motorized cold therapy unit for purchase only is not medically necessary.

Tizanidine 4mg Qty: 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-sedating Muscle Relaxants.

Decision rationale: The California (MTUS) Chronic Pain Medical Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic LBP. The documents submitted indicated the injured worker received prior conservative care; however, the outcome measurements were not provided. Furthermore, the documentation failed to indicate how long the injured worker has been on Tizanidine and functional improvement while being on the medication. The request for Tizanidine 4mg Qty: 60 is not medically necessary.

Omeprazole 20mg Qty: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & Cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

Decision rationale: Per California Medical Treatment Utilization Schedule (MTUS) Guidelines, Omeprazole is recommended for patients taking NSAIDs who are at risk of gastrointestinal events. The documentation provided did indicate that the injured worker was having gastrointestinal events. The request failed to include frequency and dosage of medications. Therefore, the request for Omeprazole 20mg QTY: 60 is not medically necessary.