

Case Number:	CM14-0079786		
Date Assigned:	08/06/2014	Date of Injury:	03/06/2014
Decision Date:	01/02/2015	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	05/30/2014

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 & Rehabilitation, has a subspecialty in Pain & Spinal Cord Medicine and is licensed to practice in Massachusetts. 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 claimant is a 29 year-old male with a history of a cumulative trauma work injury with a date of injury of 03/06/14 after he developed a pulling sensation in his low back while picking up heavy pieces of metal. He is also being treated for neck, hip and left shoulder pain. He was seen on 04/29/14. His history of injury was reviewed. He was having pain rated at 5-7/10. He had complaints of anxiety, crying spells, depression, stress, and "sexual dysfunction." He had a skin rash. Physical examination findings included a rash over the neck. There was cervical and lumbar paraspinous muscle and spinous process tenderness. There was decreased and painful spinal range of motion. Cervical compression and shoulder depression tests were positive. There was decreased and painful left shoulder range of motion. There was tenderness over the sacroiliac joints. Multiple authorizations were requested. He was seen for a Functional Capacity Evaluation on 05/12/14. He was found to have a light PDL capacity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 500mg (quantity not specified): 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) Treatment in Workers Compensation (TWC); Pain Procedure Summary- NSAID's

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 73.

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. Oral NSAIDs (nonsteroidal anti-inflammatory medications) are recommended for treatment of chronic persistent pain and for control of inflammation as in this case. Dosing of naproxen is 275-550 mg twice daily and the maximum daily dose should not exceed 1100 mg. In this case, the requested dose is not specified and therefore not medically necessary.

Naprosyn 550mg (quantity not specified): 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) Treatment in Workers Compensation (TWC); Pain Procedure Summary- NSAID's.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 73.

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. Oral NSAIDs (non-steroidal anti-inflammatory medications) are recommended for treatment of chronic persistent pain and for control of inflammation as in this case. Dosing of Naproxen is 275-550 mg twice daily and the maximum daily dose should not exceed 1100 mg. In this case, the requested dose is not specified and therefore not medically necessary.

Omeprazole 20mg (quantity not specified): 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) Treatment in Workers Compensation (TWC); Pain Procedure Summary- GI Events

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 68-71.

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. In this case, the claimant does not have any identified risk factors for a gastrointestinal event. He is under age 65 and has no history of a peptic ulcer, bleeding, or perforation. There is no documented history of dyspepsia secondary to non-steroidal anti-inflammatory medication therapy. The claimant is not being prescribed an SSRI (selective serotonin reuptake inhibitor) class medication. Therefore, the prescribing of a proton pump inhibitor such as Omeprazole was not medically necessary.

Prilosec 20mg (quantity not specified): 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) Treatment in Workers Compensation (TWC); Pain Procedure Summary- GI Events

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 68-71.

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. In this case, the claimant does not have any identified risk factors for a gastrointestinal event. He is under age 65 and has no history of a peptic ulcer, bleeding, or perforation. There is no documented history of dyspepsia secondary to non-steroidal anti-inflammatory medication therapy. The claimant is not being prescribed an SSRI (selective serotonin reuptake inhibitor) class medication. Therefore, the prescribing of a proton pump inhibitor such as Prilosec was not medically necessary.

Chiropractic Treatments 2 times a week for 5 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 203, 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Neck & Upper Back and Low Back Procedure Summary-Chiropractic Guidelines

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

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. Although chiropractic care is recommended as an option in the treatment of chronic pain, guidelines recommend a trial of 6 visits over 2 weeks with further treatment considered if there is objective evidence of functional improvement. In this case, the number of treatment sessions requested is in excess of the guideline recommendation and therefore not medically necessary.

Physical Therapy 3 times a week for 5 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174, 181, 287-289, 298. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Neck & Upper Back, Shoulder and Low Back Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine treatment, Preface, Physical Therapy Guidelines.

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. In terms of physical therapy in the treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal

reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended and therefore not medically necessary.

EMG bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Low Back Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back-Lumbar & Thoracic (Acute & Chronic), EMGs (electromyography)

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. An EMG (electromyography) is recommended as an option to obtain unequivocal evidence of radiculopathy. In this case, the presence of radiculopathy is not supported based on the claimant's symptoms and the physical examinations performed. Therefore the requested bilateral lower extremity EMG is not medically necessary.

NCV bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back-Lumbar & Thoracic (Acute & Chronic), Nerve conduction studies (NCS).

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. Nerve conduction studies (NCS) for lumbar radiculopathy are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of lumbar radiculopathy. Therefore the requested bilateral lower extremity NCV is not medically necessary.

X-ray left shoulder, cervical and lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182, 214, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Neck & Upper Back Procedure Summary, Low Back and Shoulder Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); (1) Shoulder

(Acute & Chronic), Radiography (2) Neck and Upper Back (Acute & Chronic), Radiography (x-rays) (3) Low Back-Lumbar & Thoracic (Acute & Chronic), Radiography (X-rays).

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. Applicable criteria for obtaining a cervical spine x-ray are chronic pain if this were to be the first study or in the setting of acute trauma. In this case, there is no identified acute injury. Prior records were not reviewed when this request was made. Repeating a study that may have already been performed is not considered medically necessary. For the shoulder, plain radiographs should be routinely ordered for patients with chronic shoulder pain, including anteroposterior, scapular Y, and axillary views. In this case, prior records were not reviewed when this request was made. Repeating a study that may have already been performed is not considered medically necessary. Applicable criteria for obtaining a lumbar spine x-ray are trauma or if there are 'red flags' such as suspicion of cancer or infection. In this case, there is no identified acute injury or 'red flag' and therefore the lumbar spine x-ray is not medically necessary.

MRI Lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Low Back-Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging): Indi.

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. Applicable criteria for obtaining an MRI would include a history of trauma with neurological deficit and when there are 'red flags' such as suspicion of cancer or infection or when there is radiculopathy with severe or progressive neurologic deficit. In this case, there is no identified new injury. There are no identified 'red flags' or radiculopathy with severe or progressive neurologic deficit that would support the need for obtaining an MRI scan which therefore is not medically necessary.

Ultrasound: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174, 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. Therapeutic ultrasound is

not recommended in the treatment of chronic pain. The effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. Therefore the ultrasound treatments were not medically necessary.

Referral to Psychologist: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101.

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. Psychological evaluations are generally accepted; well-established diagnostic procedures used in pain problems and should determine if further psychosocial interventions are indicated. In this case, a non-organic component to the claimant's chronic pain is suspected and the requested psychological evaluation is medically necessary.

Referral to Urologist: 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) Treatment in Workers Compensation (TWC); Pain Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: (1) Chapter 7: Independent Medical Examinations and Consultations, page 127 (2) Erectile Dysfunction Guideline Update Panel. The management of erectile dysfunction: an update. Baltimore (MD): American Urological Association Education and Research Inc 2005.

Decision rationale: The claimant is more than 6 months status post work-related injury and is being treated for chronic low back, neck, hip, and left shoulder pain. Guidelines recommend consideration of a consultation if clarification of the situation is necessary. In this case, the claimant's sexual dysfunction is not adequately described and therefore, the requested urology referral is not medically necessary.