MAXIMUS Federal Services

Case Number:	CM15-0003957		
Date Assigned:	01/14/2015	Date of Injury:	06/26/2014
Decision Date:	03/10/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Emergency Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 48 year old female sustained a work related injury on 06/26/2014. According to a progress report dated 10/15/2014, the injured worker was seen for re-evaluation of pain in the neck and bilateral shoulders. She continued to complain of headaches. Diagnoses included cervical spine, possible disc bulge with right sided C6 radiculopathy, right shoulder partial rotator cuff tear and left shoulder impingement syndrome with rotator cuff tendinitis. Range of motion was decreased in the cervical spine and shoulders. Sensory examination revealed decreased sensation to the dorsoradial aspect of the right hand. Motor with wrist extension was decreased in the right. The injured worker was temporarily totally disabled. Physical Therapy progress notes were not submitted for review.On 12/23/2014, Utilization Review non-certified MRI of the lumbar spine, physical therapy to include ultrasound, massage and therapeutic exercises (cervical, lumbar, right shoulder) and Retrospective usage of Ambien 5mg #60 and modified prospective usage of Soma 350mg #60. According to the Utilization Review physician, in regard to the MRI, there was no clear indication that the claimant had neurological deficits on exam and there was no evidence of sensory alteration and motor weakness in the lumbar spine and lower extremities. In addition, there was no clear rationale provided as to why this claimant needed imaging. CA MTUS ACOEM was cited. In regard to physical therapy, the injured worker had pain and symptoms in the cervical spine, lumbar spine and right shoulder and had been treated with physical therapy since 07/15/2014. However, submitted reports did not indicate if the claimant had made significant progress since starting therapy. There was no clear objective and functional gains noted. There was no indication of how many sessions had been completed. CA MTUS Chronic

Pain Medical Treatment Guidelines Physical Medicine was cited. In regards to retrospective Ambien, there was no documentation indicating the claimant's current symptoms of sleep dysfunction or specific documentation indicating efficacy with prior use of this medication. Official Disability Guidelines and Mosby's Drug Consult was cited. In regards to prospective usage of Soma, there was no evidence of objective functional improvement. CA MTUS Chronic Pain Medical Treatment Guidelines were cited. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Special Studies and Diagnostic and Therapeutic Considerations.

Decision rationale: The requested MRI of the lumbar spine is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 12, Lower Back Complaints, Special Studies and Diagnostic and Therapeutic Considerations, Pages 303-305, recommend imaging studies of the lumbar spine with "Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option". The injured worker has headaches as well as pain to the cervical spine, lumbar spine and right shoulder. The treating physician has documented: Range of motion was decreased in the cervical spine and shoulders. Sensory examination revealed decreased sensation to the dorsoradial aspect of the right hand. Motor with wrist extension was decreased in the right. The treating physician has not documented a positive straight leg raising test, nor deficits in dermatomal sensation, reflexes or muscle strength to the lower extremities.

Physical therapy to include ultrasound, massage, and therapeutic exercises (cervical, lumbar, right shoulder): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Page 300. Decision based on Non-MTUS Citation ODG Physical Therapy Guidelines, Low Back Complaints, Physical Therapy

Decision rationale: CA MTUS, ACOEM 2nd Edition, 2004, Chapter 12, Low Back Complaints, Page 300 and ODG Treatment in Workers Compensation, ODG Physical Therapy Guidelines, Low Back Complaints, Physical Therapy, recommend continued physical therapy with documented derived functional benefit. The injured worker has headaches as well as pain to the

cervical spine, lumbar spine and right shoulder. The treating physician has documented: Range of motion was decreased in the cervical spine and shoulders. Sensory examination revealed decreased sensation to the dorsoradial aspect of the right hand. Motor with wrist extension was decreased in the right. The treating physician has not documented sufficient objective evidence of derived functional benefit from completed physical therapy sessions. The criteria noted above not having been met, physical therapy is not medically necessary.

Prospective usage of Soma 350mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol, Page 29; Muscle Relaxants, Pages 63-66 Page(s): 29, 63-66.

Decision rationale: CA MTUS Chronic Pain Treatment Guidelines, Carisoprodol, Page 29, specifically do not recommend this muscle relaxant, and Muscle Relaxants, Pages 63-66 do not recommend muscle relaxants as more efficacious that NSAID s and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has headaches as well as pain to the cervical spine, lumbar spine and right shoulder. The treating physician has documented: Range of motion was decreased in the cervical spine and shoulders. Sensory examination revealed decreased sensation to the dorsoradial aspect of the right hand. Motor with wrist extension was decreased in the right. The treating physician has not documented spasticity or hypertonicity on exam, intolerance to NSAID treatment, nor objective evidence of derived functional improvement from its previous use. The criteria noted above not having been met, Prospective usage of Soma 350mg #60 is not medically necessary.

Retrospective usage of Ambien 5mg #60 (DOS 11/24/2014): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Treatment for Workers' Compensation; Pain Procedure Summary- Zolpidem (Ambien)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG -TWC, Integrated Treatment/Disability Duration Guidelines, Pain (Chronic), (updated 07/10/14), Insomnia Medications

Decision rationale: CA MTUS is silent. ODG -TWC, Integrated Treatment/Disability Duration Guidelines, Pain (Chronic), (updated 07/10/14), Insomnia Medications; note "Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to sixweeks) treatment of insomnia". The injured worker has headaches as well as pain to the cervical spine, lumbar spine and right shoulder. The treating physician has documented: Range of motion was decreased in the cervical spine and shoulders. Sensory examination revealed decreased sensation to the dorsoradial aspect of the right hand. Motor with wrist extension was decreased in the right. The treating physician has not documented current sleep disturbance, results of sleep behavior modification attempts or any derived functional

benefit from its previous use.The criteria noted above not having been met, Retrospective usage of Ambien 5mg #60 (DOS 11/24/2014) is not medically necessary.