

Case Number:	CM15-0008587		
Date Assigned:	01/26/2015	Date of Injury:	09/30/2014
Decision Date:	03/26/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/15/2015

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 48-year-old male who reported an injury on 09/30/2014, due to an unspecified mechanism of injury. On 01/15/2015, he presented for a followup evaluation. He reported pain in the upper, mid and lower back that was intermittent and frequent and radiated to the bilateral lower extremities, right greater than the left. He also reported occasional headaches to the back of the head. He rated his pain at a 4/10. He was noted to be taking naproxen 550 mg daily, Tylenol No. 3 as needed for severe pain, cyclobenzaprine 7.5 mg at bedtime as needed and omeprazole 20 mg daily. A physical examination indicated that the injured worker had undergone electrodiagnostic studies of the lower extremities on 12/19/2014, which showed left sided S1 lumbar radiculopathy. He was diagnosed with lumbosacral joint ligament sprain and strain, cervical sprain and strain, and thoracic sprain and strain. The treatment plan was for 1 EMG/NCS of the lower extremities, 1 prescription of cyclobenzaprine 7.5 mg #60, 1 prescription of omeprazole 20 mg #60 and 1 prescription of Tylenol No. 3 #90. The rationale for treatment was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 EMG/NCS of the lower extremities: 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): 303-305.

Decision rationale: According to the California ACOEM Guidelines, unequivocal objective findings that identify specific nerve root compromise on the neurologic examination are sufficient evidence to warrant imaging in those who do not respond to treatment and who consider surgery an option. The documentation provided indicates that the injured worker had already undergone electrodiagnostic studies on 12/19/2014. Therefore, without documentation showing that he has had a significant change in his symptoms, repeat electrodiagnostic studies would not be supported. Also, there is a lack of documentation showing that he has tried and failed recommended conservative therapy, such as physical therapy. Also, there were no neurological findings noted on the physical examination to support the request. Therefore, the request is not supported. As such, the request is not medically necessary.

1 Prescription of Cyclobenzaprine 7.5mg #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 Muscle Relaxants Page(s): 63.

Decision rationale: The California MTUS Guidelines state that nonsedating muscle relaxants are recommended with caution as a second line treatment option for acute low back pain. The documentation provided does not indicate that the injured worker has had a quantitative decrease in pain or an objective improvement in function to support its continuation. Also, further clarification is needed regarding how long the injured worker has been using this medication, as it is only recommended for short term treatment. Furthermore, the frequency of the medication was not provided within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

1 Prescription of Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS/GI Risks Page(s): 67-68.

Decision rationale: The California MTUS Guidelines recommend proton pump inhibitors such as omeprazole for the treatment of dyspepsia secondary to NSAID use and for those who are at high risk for gastrointestinal events due to NSAID therapy. The documentation provided does not indicate that the injured worker has dyspepsia secondary to NSAID use or that he is at high

risk for developing gastrointestinal events due to NSAID therapy. Also, the frequency of the medication was not provided within the request. Therefore, the requested medication is not supported. As such, the request is not medically necessary.

1 Prescription of Tylenol #3 #90: 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 On-Going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines indicates that an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects be performed during opioid therapy. Based on the clinical documentation submitted for review, the injured worker was noted to be taking Tylenol No. 3 as needed for severe pain. However, there is a lack of documentation showing an objective improvement in function or a quantitative decrease in pain with the use of this medication to support its continuation. Also, no official urine drug screens or CURES reports were provided for review to validate his compliance. Furthermore, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.