

Case Number:	CM15-0018138		
Date Assigned:	02/06/2015	Date of Injury:	09/03/2014
Decision Date:	05/20/2015	UR Denial Date:	01/02/2015
Priority:	Standard	Application Received:	01/30/2015

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: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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:

The injured worker is a 58 year old female, who sustained a work related injury on 9/3/14. The mechanism of injury involved a fall. The injured worker is currently diagnosed with right elbow contusion, low back contusion, lumbar sprain, right shoulder sprain, low back pain, and right elbow pain. The latest physician progress note submitted for review is documented on 09/09/2014. The injured worker presented for a follow up evaluation, with complaints of minimal low back pain. The injured worker also reported minimal right shoulder pain. There were no subjective complaints of tingling, numbness, or weakness. The current medication regimen includes Tylenol 500 mg, Meloxicam 7.5 mg, and Omeprazole DR 20 mg. Upon examination of the right shoulder, there was no evidence of tenderness or subluxation. There was no documentation of any weakness with regard to the bilateral upper extremities. There was full range of motion of the right shoulder. There was no evidence of tenderness in the paravertebral musculature, nor evidence of palpable muscle spasm. There was no restriction of range of motion of the lumbar spine. Deep tendon reflexes were normal and symmetrical. Sensation was intact to light touch and pinprick in all dermatomes in the bilateral lower extremities. The injured worker was released from care and was to return to full duty on 09/09/2014, without limitations or restrictions. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray of the lumbosacral spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The CA MTUS/ACOEM Practice Guidelines state lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags or serious pathology, even if the pain has persisted for at least 6 weeks. In this case, there was no documentation of a musculoskeletal or neurological deficit upon examination. The medical necessity for a lumbar spine x-ray has not been established. The injured worker was released from care to return to work without restriction. Given the above, the request is not medically appropriate.

X-ray of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The CA MTUS/ACOEM Practice Guidelines state for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. In this case, the injured worker reported only minimal right shoulder pain. There was no documentation of a musculoskeletal or neurological deficit upon examination. The medical necessity for an x-ray of the right shoulder has not been established in this case. As such, the request is not medically necessary.

X-ray of the right elbow: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42-43.

Decision rationale: The CA MTUS/ACOEM Practice Guidelines state, for most patients presenting with elbow problems, special studies are not needed unless a period of at least 4 weeks of conservative care and observation fails to improve symptoms. In this case, there was no documentation of a musculoskeletal or neurological deficit with regard to the right upper

extremity. The medical necessity has not been established in this case. Therefore, the request is not medically necessary.

Physical performance-FCE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a number of functional assessment tools are available including Functional Capacity Examination when reassessing function and functional recovery. The Official Disability Guidelines recommend a Functional Capacity Evaluation if case management has been hampered by complex issues, and the timing is appropriate. In this case, there was no indication that this injured worker was unable to return to work. The injured worker had reached maximum medical improvement and was released to full duty without restriction. There is limited evidence that the injured worker has failed to return to work. The medical necessity has not been established. As such, the request is not medically necessary.

Urine toxicology: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77, and 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

Decision rationale: The California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. Patients at low risk of addiction or aberrant behaviors should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the clinical notes submitted, there is no mention of non-compliance or misuse of medication. There is no indication that this injured worker falls under a high risk category that would require frequent monitoring. Therefore, the current request is not medically necessary.

Lumbosacral brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The CA MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptoms relief. In this case, there was no documentation of a musculoskeletal or neurological deficit upon examination. The medical necessity for a lumbosacral brace has not been established. There was no evidence of spinal instability upon examination. Given the above, the request is not medically necessary.

Inferential Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: The California MTUS Guidelines state that interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications. There should be documentation that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse or significant pain from postoperative conditions. In this case, there was no evidence of a failure of conservative treatment prior to the request for an interferential unit. There is no evidence of a musculoskeletal or neurological deficit upon examination. There is also no documentation of a successful 1 month trial prior to the request for a unit purchase. Given the above, the request is not medically necessary.

Hot and Cold Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The CA MTUS/ACOEM Practice Guidelines state at home local applications of heat or cold are as effective as those performed by a therapist. In this case, there was no documentation of a musculoskeletal or neurological deficit upon examination. There is no mention of a contraindication to at home local applications of heat or cold packs, as opposed to a motorized mechanical device. As the medical necessity has not been established, the request is not medically necessary.