

Case Number:	CM15-0141240		
Date Assigned:	07/29/2015	Date of Injury:	06/03/2004
Decision Date:	09/15/2015	UR Denial Date:	07/13/2015
Priority:	Standard	Application Received:	07/21/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 63-year-old male sustained an industrial injury on 6/03/04. He subsequently reported back and right foot pain. Diagnoses include herniated nucleus pulposus, thoracic sprain and sprain and foot pain due to plantar fasciitis. Treatments to date include MRI testing, lumbar spine surgery, physical therapy, modified work duty and prescription pain medications. The injured worker reports continued mid back, low back and right foot pain. Upon examination, there was spasm noted in the thoracic area. Lying straight leg raising test was positive bilaterally. A request for MRI (magnetic resonance imaging) Thoracic Spine, (retrospective DOS 4/15/15), Tylenol #4, Qty 90, (retrospective DOS 4/15/15), Prilosec 20 mg Qty 90, (retrospective DOS 4/15/15) and X-Force with SolarCare, Qty 1, (retrospective DOS 4/15/15) was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging) Thoracic Spine, (retrospective DOS 4/15/15): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-177.

Decision rationale: Regarding the request for thoracic MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Guidelines also recommend MRI after 3 months of conservative treatment. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally there is no documentation of neurologic deficit or failure of conservative treatment for at least 3 months. In the absence of such documentation, the requested thoracic MRI is not medically necessary.

Tylenol #4, Qty 90, (retrospective DOS 4/15/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-80.

Decision rationale: Regarding the request for Tylenol #4 (acetaminophen/codeine), Chronic Pain Medical Treatment Guidelines state that Tylenol #4 is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function (in terms of specific examples of functional improvement), and no documentation regarding side effects. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Tylenol #4 (acetaminophen/codeine) is not medically necessary.

Prilosec 20 mg Qty 90, (retrospective DOS 4/15/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain (chronic) - Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68-69.

Decision rationale: Regarding the request for Omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested Omeprazole (Prilosec) is not medically necessary.

X-Force with SolarCare, Qty 1, (retrospective DOS 4/15/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation). Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar & Thoracic (Acute & Chronic) - Infrared therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203-4, Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

Decision rationale: With regard to this request for X Force stimulator with Solar Care Heating System, the ACOEM, Shoulder Complaints Chapter, on pages 203-4 state the following: "Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasound treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high-quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapists available for referral. The peer reviewed literature and evidenced based guidelines including the MTUS and ACOEM do not support a heating system with infrared technology as opposed to a simpler system of heating pad. Given this, the request of X force stimulator with Solar Care is not medically necessary."