

Case Number:	CM15-0164149		
Date Assigned:	09/02/2015	Date of Injury:	04/18/2014
Decision Date:	10/20/2015	UR Denial Date:	07/27/2015
Priority:	Standard	Application Received:	08/21/2015

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:

The injured worker is a 49 year old male who sustained an industrial injury on 4-18-14. The Worker's Compensation Initial Evaluation Report, dated 7-1-15, indicates that the injury "occurred while he was lifting, pushing, pulling, bending, stooping, kneeling and prolonged repetitive power gripping while at his job". On examination, he complained of "discomfort in his left sacroiliac, sacral, right sacroiliac, left buttock, right buttock, left lumbar, lumbar, left posterior leg, left posterior knee, left calf, left ankle, left foot, left anterior knee, left shin, left ankle and left foot area". He rated the pain "6 out of 10". The report indicates that the pain was "gradual" and was "first noticed" in April 2014. He also complained of a "secondary complaint" in his "right cervical dorsal, left cervical dorsal, upper thoracic, left posterior shoulder, right posterior shoulder, left posterior wrist and left anterior wrist region". He rated that pain "7 out of 10". He reported that the symptoms have progressed since he first reported them. He was examined and diagnosed with lumbar intervertebral disc disorder with myelopathy, lumbar sprain or strain, sprain or strain of the shoulder, and sprain or strain of the wrist. The treatment recommendations were noted to be physiotherapy of the lumbar spine, right shoulder, left shoulder, and left wrist, an MRI of the lumbar spine, bilateral shoulders, and left wrist, shockwave ultrasound therapy for the bilateral shoulders, a compound cream of Flurbiprofen-Baclofen-Dexamethasone-Menthol-Caphor-Capsaicin-Hyaluronic acid, as well as Naproxen and Prilosec. A progress report dated September 1, 2015 ongoing low back pain, hip pain, and lower extremity pain. He also complains of pain in the right cervical area left cervical area, upper thoracic and bilateral shoulders and upper extremities. Physical exam revealed decreased range

of motion in the lumbar spine, bilateral wrists, and left > right shoulder. The patient is noted to have normal deep tendon reflexes. The report summarizes an undated MRI of the lumbar spine. MRI of the left shoulder dated September 3, 2015 is available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors (PPIs).

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.

Compound Rx. 180gm: Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Champor 2%, Capsaicin 0.0375%, Hyaluronic Acid 0.20%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Compound Rx. 180gm: Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Champor 2%, Capsaicin 0.0375%, and Hyaluronic Acid 0.20%, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants drugs are not supported by the CA MTUS for topical use. Guidelines do not support the use of topical Hyaluronic Acid. As such, the currently requested Compound Rx. 180gm: Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Champor 2%, Capsaicin 0.0375%, Hyaluronic Acid 0.20% is not medically necessary.

MRI Left Wrist: 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), Forearm, Wrist, & Hand Chapter.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand and Carpal Tunnel Syndrome Chapters.

Decision rationale: Regarding the request for MRI of the left wrist, California MTUS and ACOEM note that imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. More specifically, ODG notes that MRIs for carpal tunnel syndrome are not recommended in the absence of ambiguous electrodiagnostic studies. In general, they are supported in chronic wrist pain if plain films are normal and there is suspicion of a soft tissue tumor or Kienbock's disease. Within the documentation available for review, there is no clear indication of a condition for which an MRI is supported as noted above or another clear rationale for the use of MRI in this patient. Additionally, no physical exam findings suggesting serious pathology have been identified, and there is no documentation of failed conservative treatment. In the absence of such documentation, the currently requested MRI of the left wrist is not medically necessary.

MRI Right Shoulder: 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), Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI).

Decision rationale: Regarding the request for MRI of the right shoulder, Occupational Medicine Practice Guidelines state that more specialized imaging studies are not recommended during the 1st month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines go on to recommend imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends MRI of the shoulder for subacute shoulder pain with suspicion of instability/labral tear or following acute shoulder trauma with suspicion of rotator cuff tear/impingement with normal plain film radiographs. Within the documentation available for review, it does not appear the patient has failed conservative treatment options. Furthermore, it is unclear how an MRI will change the patient's current treatment plan. In the absence of clarity regarding those issues, the currently requested right shoulder MRI is not medically necessary.

MRI Left Shoulder: 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), Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI).

Decision rationale: Regarding the request for repeat MRI of the left shoulder, Occupational Medicine Practice Guidelines state that more specialized imaging studies are not recommended during the 1st month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines go on to recommend imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends MRI of the shoulder for subacute shoulder pain with suspicion of instability/labral tear or following acute shoulder trauma with suspicion of rotator cuff tear/impingement with normal plain film radiographs. ODG goes on to state that they repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Within the documentation available for review, there is no indication of any significant change in the patient symptoms and/or findings suggesting a significant worsening of the patient's pathology or a new issue which needs to be evaluated by MRI. Additionally, there is no documentation of failed conservative treatment. In the absence of clarity regarding those issues, the currently requested repeat left shoulder MRI is not medically necessary.

MRI Lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRIs (magnetic resonance imaging).

Decision rationale: Regarding the request for lumbar MRI, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. ODG states that MRIs are recommended for uncomplicated low back

pain with radiculopathy after at least one month of conservative therapy. Within the documentation available for review, there is no identification of any objective findings that identify specific nerve compromise on the neurologic exam. Additionally, there is no statement indicating what medical decision-making will be based upon the outcome of the currently requested MRI. Furthermore, there is no documentation of recently failed conservative treatment directed towards the patient's current complaints. In the absence of clarity regarding those issues, the currently requested lumbar MRI is not medically necessary.

Physical Therapy left wrist, right shoulder, left shoulder, lumbar 2 x 3: 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), Low Back, Shoulder, Forearm, Wrist & Hand Chapter, and Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Regarding the request for Physical Therapy left wrist, right shoulder, left shoulder, lumbar 2 x 3, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of any specific objective treatment goals for each individual body part and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Additionally, it is unclear if physical therapy has previously been provided for any of the requested body parts. If so, there is no documentation of objective functional improvement from those previous therapy sessions. In the absence of clarity regarding those issues, the current request for Physical Therapy left wrist, right shoulder, left shoulder, lumbar 2 x 3 is not medically necessary.