

Case Number:	CM15-0180784		
Date Assigned:	09/22/2015	Date of Injury:	05/21/2015
Decision Date:	11/18/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/14/2015

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: New York
 Certification(s)/Specialty: Internal 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 30 year old female sustained an industrial injury on 5-21-15. Documentation indicated that the injured worker was receiving treatment for low back, neck, foot and right shoulder pain. Previous treatment included physical therapy and medications. In a PR-2 dated 7-16-15, the injured worker complained of intermittent low back, neck and right shoulder pain, rated 7 out of 10 on the visual analog scale. The injured worker reported that her pain increased after physical therapy was stopped. Physical exam was remarkable for right shoulder with tenderness to palpation, positive impingement sign and range of motion: flexion 180 degrees, extension 50 degrees, abduction 70 degrees, adduction 50 degrees and internal and external rotation 90 degrees and tenderness to palpation to the right lateral foot and heel. The treatment plan included continuing medications (Naproxen Sodium, Cyclobenzaprine and Omeprazole), magnetic resonance imaging right shoulder and physical therapy. In an initial evaluation dated 8-12-15, the injured worker complained of right shoulder, elbow and wrist pain with radiation to the right fingers associated with numbness, low back pain with radiation to the feet, neck pain with radiation to the hands, mid back pain and left heel pain. Physical exam was remarkable for cervical spine with tenderness to palpation, muscle spasms, decreased range of motion and positive cervical compression test, thoracic spine with tenderness to palpation and decreased range of motion, lumbar spine with tenderness to palpation, spasms, positive right straight leg raise and decreased range of motion, right shoulder with tenderness to palpation and spasms, range of motion: abduction 100 degrees, adduction 20 degrees, extension 26 degrees, external rotation 42 degrees, flexion 120 degrees and internal rotation 38 degrees and right elbow with

tenderness to palpation, decreased range of motion and positive Tinel's. The treatment plan included a trial of chiropractic therapy, medications (Naproxen Sodium, Omeprazole, Cyclobenzaprine, Keto ointment, FCMC ointment) an interferential unit, x-rays of the cervical spine, lumbar spine, right shoulder, right wrist and right elbow and magnetic resonance imaging of the cervical spine, lumbar spine, right shoulder and right wrist. On 9-4-15, Utilization Review noncertified a request for Omeprazole 20mg #60, Cyclobenzaprine 7.5mg #60, Keto ointment 120mg, and FCMC ointment 120mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Proton Pump Inhibitors (PPIs) are used to treat gastrointestinal conditions such as Gastroesophageal reflux disease, Dyspepsia and Gastric ulcers, and to prevent ulcerations due to long term use of Non-steroidal anti-inflammatory drugs (NSAIDs). MTUS recommends the combination of NSAIDs and PPIs for patients at risk for gastrointestinal events, including age over 65 years of age, history of peptic ulcer, gastrointestinal bleeding, or perforation, concurrent use of ASA and high dose or multiple NSAIDs. Documentation does not support that the injured worker is at high risk of gastrointestinal events to establish the medical necessity of ongoing use of Omeprazole. The request for Omeprazole 20 mg, sixty count is not medically necessary per MTUS guidelines.

Cyclobenzaprine 7.5 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system depressant recommended as a treatment option to decrease muscle spasm in conditions such as low back pain. Per MTUS guidelines, muscle relaxants are recommended for use with caution as a second-line option for only short-term treatment of acute exacerbations in patients with chronic low back pain. The greatest effect appears to be in the first 4 days of treatment and appears to diminish over time. The injured worker complains of persistent neck and low back pain. Documentation fails to indicate acute exacerbation or significant improvement in the injured worker's pain or functional status to justify continued use of

cyclobenzaprine. The request for Cyclobenzaprine 7.5 mg, sixty count is not medically necessary per MTUS guidelines.

Keto ointment, 120 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: MTUS states that topical NSAIDs are not recommended for neuropathic pain, but may be useful for short-term treatment (4-12 weeks) of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). Topical NSAIDs have not been evaluated for treatment of the spine, hip or shoulder. There are no long-term studies of their effectiveness or safety. Per MTUS, Ketoprofen is not recommended and is not currently FDA approved for a topical application. With guidelines not being met, the request for Keto ointment, 120 grams is not medically necessary.

FCMC ointment 120 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Flurbiprofen is not FDA approved for topical application and MTUS provides no evidence recommending the use of topical Menthol or Camphor. Per guidelines, any compounded product such as FCMC (containing Flurbiprofen, Capsaicin, Menthol and Camphor) that contains at least one drug (or drug class) that is not recommended is not recommended. The request for FCMC Ointment 120 gm is not medically necessary by MTUS.

Trial of chiropractic for the lumbosacral region, twice weekly for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: MTUS recommends a trial of 6 Chiropractic visits over 2 weeks for initial treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks may be prescribed. Per MTUS, elective/maintenance care is not medically necessary. Documentation provided for review reveals that the injured worker has had initial trial of physical therapy, but there is lack of detailed information regarding objective clinical outcome of the treatment. Given that there is no report of significant improvement in physical function or exceptional factors, medical necessity for chiropractic treatment has not been established. Per guidelines, the request for Trial of chiropractic for the lumbosacral region, twice weekly for four weeks is not medically necessary.

Massage therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: MTUS recommends Massage therapy as an adjunct to other treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. Documentation provided fails to demonstrate that the injured worker has had significant improvement in pain with previous treatment modalities, including physical therapy, to justify the medical necessity for massage therapy. The request for Massage therapy is not medically necessary per guidelines.

Diathermy EG microwave: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Manipulation Chapter, Diathermy.

Decision rationale: Diathermy is a type of heat treatment using either short wave or microwave energy. Per guidelines, it is not recommended and has not been proven to be more effective than placebo diathermy or conventional heat therapy. With guidelines not being met, the request for Diathermy EG microwave is not medically necessary.

Electric stim other than wound: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official

Disability Guidelines (ODG) Pain Chapter, Electrical stimulation, Neuromuscular electrical stimulation (NMES devices).

Decision rationale: Per guidelines, Neuromuscular electrical stimulation (NMES devices) is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. MTUS and ODG do not recommend electrical stimulation for the treatment of pain. With guidelines not being met, the request for Electric stim other than wound is not medically necessary.

X-ray of the LS spine, 2/3 views x 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.Char Format Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: MTUS recommends Lumbar spine x rays in patients with low back pain only when there is evidence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Documentation fails to show objective clinical evidence of specific nerve compromise on the neurologic examination or acute exacerbation of the injured worker's symptoms of low back pain to support the medical necessity for additional imaging. The request for X-ray of the LS spine, 2/3 views x 1 is not medically necessary per MTUS.

X-ray of right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

Decision rationale: MTUS recommends ordering imaging studies when there is evidence of a red flag on physical examination (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker complains of right shoulder pain. Chart documentation fails to show any red flags or unexplained physical findings on examination that would warrant additional imaging. The request for X-ray of right shoulder is not medically necessary by MTUS.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: MTUS recommends Lumbar spine x rays in patients with low back pain only when there is evidence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The injured worker complains of ongoing low back pain. Documentation fails to show objective clinical evidence of specific nerve compromise on the neurologic examination or acute exacerbation of the injured worker's symptoms. There is lack of Physician report indicating that surgery is being considered. The request for MRI of the lumbar spine is not medically necessary per MTUS.

MRI joint upper extremity, right shoulder, plain: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

Decision rationale: MTUS recommends ordering imaging studies when there is evidence of a red flag on physical examination (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker complains of ongoing right shoulder pain. Chart documentation fails to show any red flags or unexplained physical findings on examination to establish the medical necessity for ordering MRI. The request for MRI joint upper extremity, right shoulder, plain is not medically necessary by MTUS.

MEDS-4 INF: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: MTUS states that Interferential Current Stimulation is not recommended as isolated modality. There is very little evidence to show it is superior to standard Transcutaneous Electrical Nerve Stimulation (TENS). Electrotherapy is recommended in conjunction with other treatments, including return to work, exercise and medications. This form of treatment is appropriate for patients with significant pain from postoperative conditions that limit the ability to perform exercise programs/physical therapy treatment, or refractory to conservative measures (e.g., repositioning, heat/ice, etc.), patients whose pain is ineffectively controlled due to diminished effectiveness or side effects of medications or patients with history of substance abuse. If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. The injured worker complains of low back, neck, foot and right shoulder pain. Documentation provided for review fails to demonstrate that the injured worker is physically limited from a postoperative condition or participating in other recommended treatments, including a home exercise program. With MTUS criteria not being met, the medical necessity for an interferential unit has not been established. Subsequently, the request for MEDS-4 INF is not medically necessary.