

Case Number:	CM15-0027595		
Date Assigned:	02/19/2015	Date of Injury:	05/05/2014
Decision Date:	04/24/2015	UR Denial Date:	02/02/2015
Priority:	Standard	Application Received:	02/13/2015

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: Anesthesiology

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 26 year old female, who sustained an industrial injury on May 5, 2014. The injured worker had reported an injury to the back, neck, wrists, right hip and right ankle related to a fall. The diagnoses have included lumbar sprain/strain, thoracic sprain/strain and a lumbar sprain/strain. Treatment to date has included pain medication, physical therapy, x-rays, heat and ice treatment and a home exercise program. Documentation dated November 26, 2014 notes that the injured worker complained of low back pain with spasms. Physical examination revealed tenderness to the thoracic and lumbar paraspinal muscles. Range of motion was diminished with muscle guarding of the thoracic and lumbar spine. Sensorimotor examination was intact. Straight leg raise was negative. Current documentation dated January 8, 2015 notes that the injured worker complained of constant severe lumbar spine pain rated a ten out of ten on the Visual Analogue Scale. No physical examination was noted. On February 2, 2015 Utilization Review non-certified a request for follow up with a physician for pain medication, Omeprazole, Relafen, a urine toxicology screen, continued physical therapy 2-3 times a week for 6 weeks, MRI of lumbar spine and a back brace. The MTUS, ACOEM Guidelines, Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, were cited. On February 13, 2015, the injured worker submitted an application for IMR for review of a follow up with a physician for pain medication, Omeprazole, Relafen, a urine toxicology screen, continued physical therapy 2-3 times a week for 6 weeks, MRI of lumbar spine and a back brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow up with [REDACTED] for pain medication: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ACOEM practice guidelines, Chapter 7 independent medical examinations and consultations, page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

Decision rationale: According to CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity of the requested consultation. In addition, the exact specialty of the requested physician ([REDACTED]) is not known. There is also no documentation that diagnostic and therapeutic management has been exhausted within the present treating provider's scope of practice. Medical necessity for the requested service is not established. The requested service is not medically necessary.

Omeprazole: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors Page(s): 68.

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation indicating the patient has any GI symptoms or GI risk factors. This patient is not currently taking an NSAID. Based on the available information provided for review, the medical necessity for Omeprazole has not been established. The requested medication is not medically necessary.

Relafen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Relafen is a non-specific non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbations of chronic pain, short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, there is no documentation of the specific dosage and number of pills requested for use.

There is no documentation of a clear indication for the use of this medication. Medical necessity of the requested medication has not been established. The request for Relafen is not medically necessary.

Urine toxicology screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Urine drug testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Screen Page(s): 43.

Decision rationale: According to CA MTUS (2009), a urine drug screen is recommended as an option to assess for the use or the presence of illegal drugs. According to ODG, urine drug testing (UDT) is a recommended tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. In this case, it is not clear whether the patient is maintained on any narcotics and there is no clear indication of any other medications that require monitoring. Medical necessity for the requested item is not established. The requested item is not medically necessary.

Continue physical therapy 2-3 x week x 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 12 Low Back Complaints Page(s): 79, Chronic Pain Treatment Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back; Lumbar and Thoracic (Acute & Chronic).

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional

activities with assisting devices. In this case, the provider is requesting an additional 12 to 18 sessions of physical therapy. There is no specific indication for additional therapy. The record indicates that there are no motor or sensory deficits on exam, and only a mild degree of loss of range of motion of the thoracolumbar spine. The patient should be involved in an active home exercise program. Medical necessity for the requested PT sessions have not been established. The requested PT is not medically necessary.

MRI of lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MRI of the Lumbar Spine Page(s): 304.

Decision rationale: According to California MTUS Guidelines, MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication for a repeat MRI of the lumbar spine. There are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no unequivocal objective findings identifying any specific nerve compromise on neurologic examination. Medical necessity for the requested MRI has not been established. The requested imaging is not medically necessary.

Back brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Supports.

Decision rationale: According to ODG, lumbar supports are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). According to MTUS/ACOEM guidelines, lumbar support braces have not been shown to have lasting benefit beyond the acute phase of symptom relief. In this case, this patient is not in the acute phase of symptoms relief, and the physical exam reveals only mild tenderness of the thoracolumbar spine. There is no specific indication for a back brace. Medical necessity for the requested lumbar support brace has not been supported or established. The requested item is not medically necessary.