

Case Number:	CM15-0035543		
Date Assigned:	03/04/2015	Date of Injury:	09/26/2013
Decision Date:	04/21/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	02/25/2015

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 female, who sustained an industrial injury on 09/26/2013. On provider visit dated 01/30/2015 the injured worker has reported low back pain. The diagnoses have included lumbosacral strain mostly left sided with probable left lumbar radiculitis and left gluteal pain rule out piriformis syndrome versus referred pain form lumbar radiculitis. Treatment to date has included MRI and medication. On examination, she was noted to have slow gait, due to low back pain, and tenderness of the S1 region on left side that extended to the left gluteal region and a decreased range of motion of lumbar spine with a positive straight leg raise on left side. Treatment plan included chiropractic and physical therapy treatment , TENS unit, and continue with heat packs and ice packs, Naproxen Sodium 550mg, Omeprazole 20mg, and follow up visits. On 02/19/2015 Utilization Review non-certified Physical Therapy 2 times per week for 3 weeks, Trial of TENS Unit x1 month, Naproxen sodium 500mg, and Omeprazole 20mg and modified Heat and Ice packs and Follow up visit in 2-3 months. The CA MTUS, ACOEM, Chronic Pain Medical Treatment Guidelines and ODG were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times per week for 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PT
Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PT.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Per ODG, patients should be formally assessed after a trial (6 visits) to see the progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. There is no specific indication for the additional 6 PT (2x3) sessions requested, as the additional visits exceed the MTUS and ODG guidelines. Medical necessity for the additional PT visits requested have not been established. The requested services are not medically necessary.

Trial of TENS Unit x1 month: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS
Page(s): 114-121.

Decision rationale: Electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Transcutaneous electrotherapy is the most common form of electrotherapy where electrical stimulation is applied to the surface of the skin. According to the MTUS guidelines, the TENS (transcutaneous electrical nerve stimulation) unit is not recommended as a primary treatment modality. A one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for conditions such as, neuropathic pain, phantom limb pain, complex regional pain syndrome, spasticity, or multiple sclerosis. In this case, the patient continues to be symptomatic with LBP with radiation to the left lower extremity. PT has been previously tried without much improvement. The patient's current treatment regimen, with use of heat and ice packs, are providing significant relief of symptoms. In addition, chiropractic treatment has been certified and is pending. Given the relief of symptoms with current medications and modalities, medical necessity has not been established. The requested TENS unit is not medically necessary.

Heat and Ice packs: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cold/Heat Packs.

Decision rationale: The ODG states that cold/heat packs are recommended as a treatment option for acute pain: at-home applications of cold packs in the first few days of an acute complaint; thereafter, applications of heat packs or cold packs. The documentation indicates that the application of cold/heat packs in conjunction with the approved chiropractic treatment has proved beneficial for pain control of the low back pain flare-up instead of taking additional medications. Specialized equipment for the provision of heat or cold therapy is not recommended, therefore, standard ice bags for home use, as well as, hot moist towels for home use are supported. Medical necessity for the requested items has not been established. The requested items are not medically necessary.

Naproxen sodium 500mg: Upheld

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

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

Decision rationale: Naproxen sodium is a 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 exacerbation 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 recommend that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, there was no documentation of objective functional benefit from use of this medication. Medical necessity of the requested medication has not been established. The request for Naproxen is not medically necessary.

Omeprazole 20mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented

GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. In this case, there is no documentation indicating that the patient had any GI symptoms or risk factors. In addition, the request for Naproxen sodium was found to not be medically necessary, which would mean that Omeprazole would not appear to be medically necessary for this patient. Medical necessity for Omeprazole has not been established. Therapy with a PPI is not medically necessary for this patient.

Follow up visit in 2-3 months: Overturned

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.

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

Decision rationale: The CA MTUS/ACOEM states that a patient with work-related low back complaints should have follow-up every three to five days by a mid-level practitioner or physical therapist who can counsel the patient about avoiding static positions, medication use, activity modification, and other concerns. The need for a clinical office visit with a health care provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The requested follow-up visit is medically necessary for an evaluation of the progress of treatment, as well as to assess residual complaints and deficits, which would require continued treatment. The requested follow-up visit, in 2-3 months, is medically necessary.