

Case Number:	CM15-0081761		
Date Assigned:	05/04/2015	Date of Injury:	10/18/2010
Decision Date:	07/09/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	04/28/2015

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

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 45-year-old male who sustained an industrial injury on 10/18/10 involving his back as he lifted a four inch water hose he felt a sharp pain in his back. He had an MRI (10/18/10) of his back that revealed positive findings. He received medications and physical therapy. He was off work for three years and the treatments did not help his symptoms. Of note, he sustained another industrial injury on 6/28/13 involving his sharp pain in his right shoulder. He was prescribed medications, physical therapy and had surgery all of which helped with his symptoms and he was released back to work with restrictions. He currently complains of severe back pain and leg radiculopathies with pain, numbness and weakness. He can ambulate four blocks before he has to stop. Medications are Menthoderm, Prilosec, Tramadol, and Neurontin. Diagnoses include lumbar disc herniation with bilateral foraminal stenosis at L2 to L5; discogenic changes at L2 to L5. Treatments to date per note 1/22/15 include extensive conservative care and injectional care to the lumbar spine without improvement. Diagnostics include MRI of the lumbar spine with and without load bearing (11/12/14) abnormal with broad based disc herniation, disc desiccation, and hemangioma. In the progress note dated 2/12/15, the treating provider's plan of care includes refills on Prilosec, naproxen and requests a urine drug screen. The notes do not indicate interferential unit or hot/ cold pack.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, and cardiovascular risks Page(s): 69.

Decision rationale: The patient was injured on 10/18/10 and presents with lumbar spine pain. The request is for PRILOSEC. There is no RFA provided and the patient's work status is not provided. Reports provided are hand-written and partially illegible. The patient has been taking this medication as early as 01/15/15. MTUS Guidelines page 60 and 69 state that omeprazole is recommended with precaution for patients at risk for gastrointestinal events: 1. Age greater than 65. 2. History of peptic ulcer disease and GI bleeding or perforation. 3. Concurrent use of ASA or corticosteroid and/or anticoagulant. 4. High dose/multiple NSAID. MTUS page 69 states, "NSAIDs, GI symptoms, and cardiovascular risks: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2 receptor antagonist or a PPI." The reason for the request is not provided. The patient is diagnosed with lumbar disc herniation with bilateral foraminal stenosis at L2 to L5 and discogenic changes at L2 to L5. The patient is currently taking Tramadol, Naproxen, and Neurontin. In this case, the patient is not over 65, does not have a history of peptic ulcer disease and GI bleeding or perforation, does not have concurrent use of ASA or corticosteroid and/or anticoagulant, and does not have high-dose/multiple NSAID. The treater does not document dyspepsia or GI issues. Routine prophylactic use of PPI without documentation of gastric issues is not supported by guidelines without GI risk assessment. Given the lack of rationale for its use, the requested Prilosec IS NOT medically necessary.

Naproxen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Medications for chronic pain Page(s): 22, 60.

Decision rationale: The patient was injured on 10/18/10 and presents with lumbar spine pain. The request is for PRILOSEC. There is no RFA provided and the patient's work status is not provided. Reports provided are hand-written and partially illegible. The patient has been taking this medication as early as 01/15/15. MTUS Guidelines on anti-inflammatory page 22 states, "Anti-inflammatories are the traditional first line of treatment to reduce pain, so activity and functional restoration can resume, but long-term use may not be warranted." The reason for the request is not provided. The patient has a reduced lumbar spine range of motion and is diagnosed with lumbar disc herniation with bilateral foraminal stenosis at L2 to L5 and discogenic changes at L2 to L5. On 01/15/15, the patient rated his pain as a 7/10. The treater does not specifically discuss efficacy of Naproxen on any of the reports provided. MTUS Guidelines page 60 states that when medications are used for chronic pain, recording of pain and function needs to be provided. Due to lack of documentation, the requested Naproxen IS NOT medically necessary.

Urine drug screen: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Urine drug testing.

Decision rationale: The patient was injured on 10/18/10 and presents with lumbar spine pain. The request is for a URINE DRUG SCREEN. There is no RFA provided and the patient's work status is not provided. Reports provided are hand-written and partially illegible. The patient has had prior urine drug screens from 10/15/14, 11/12/14, 12/10/14, 01/20/15, 02/12/15, and 04/09/15. While MTUS Guidelines do not specifically address how frequently UDS should be obtained for various risks of opiate users, ODG Guidelines provide clear documentation. They recommend once yearly urine drug screen following initial screening with the first 6 months for management of chronic opiate use in low-risk patients. The reason for the request is not provided. The patient is diagnosed with lumbar disc herniation with bilateral foraminal stenosis at L2 to L5 and discogenic changes at L2 to L5. The patient is currently taking Tramadol, Naproxen, and Neurontin. The patient had a urine drug screen on 02/12/15 and was inconsistent with Tramadol and Des-Tramadol, which were not prescribed. The patient had another urine drug screen conducted on 04/09/15 and was not consistent with his prescribed medications. He had Hydrocodone, Norhydrocodone, and Hydromorphone in his system which were not on his prescription. The treater does not document that the patient is at high risk for adverse outcomes, or has active substance abuse disorder. The physician does not discuss what he is going to do with the inconsistent UDS results from 02/17/15 and 04/13/15. Opiate management require not just obtaining the UDS, but discussing and acting on the inconsistent results. The request for another urine drug screen IS NOT medically necessary.

IF unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The patient was injured on 10/18/10 and presents with lumbar spine pain. The request is for an IF UNIT. There is no RFA provided and the patient's work status is not provided. Reports provided are hand-written and partially illegible. The report with the request is not provided. For Interferential Current Stimulation (ICS), MTUS guidelines, pages 118 - 120, state that "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e. g. , repositioning, heat/ice, etc.). The reason for the request is not provided, nor is there any discussion provided on how the device will be used, or what body part will be treated. The patient has a reduced lumbar spine range of motion and is diagnosed with lumbar disc herniation with bilateral foraminal stenosis at L2 to L5 and discogenic changes at L2 to L5. Treatments to date includes extensive conservative care and

injectional care to the lumbar spine without improvement. There is no documentation of patient's history of substance abuse, operative condition, nor unresponsiveness to conservative measures. Documentation to support these criteria has not been met. Furthermore, MTUS requires a 30-day trial of the unit showing pain and functional benefit before a home unit is allowed. In this case, there was no 30-day trial with the interferential unit. Therefore, the requested IF unit IS NOT medically necessary.

Hot/Cold pack: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Knee chapter, Hot Cold packs Knee Chapter, Continuous flow-cryotherapy.

Decision rationale: The patient was injured on 10/18/10 and presents with lumbar spine pain. The request is for a URINE DRUG SCREEN. There is no RFA provided and the patient's work status is not provided. Reports provided are hand-written and partially illegible. The report with the request is not provided. MTUS is silent on hot/cold therapy units. ODG, Forearm, Hand and Wrist Chapter, does not discuss hot/cold therapy units or Cold/heat packs or continuous flow cryotherapy. However, ODG does provide some guidance in the Knee chapter, Hot Cold packs, which recommends ice massage and cold packs; however, hot packs had no beneficial effect on edema. Knee Chapter, Continuous flow-cryotherapy, states this is recommended as an option after surgery up to 7 days, but not for non-surgical treatment. The treater does not provide a reason for the request and it is unknown for which body part this hot/cold pack is for. The patient has a reduced lumbar spine range of motion and is diagnosed with lumbar disc herniation with bilateral foraminal stenosis at L2 to L5 and discogenic changes at L2 to L5. Treatments to date includes extensive conservative care and injectional care to the lumbar spine without improvement. In this case, there is no indication that the patient has undergone surgery or pending any surgery. ODG Guidelines do not support this type of device other than for postoperative recovery, and there is no indication that the patient has been authorized for surgery. The requested hot/cold pack IS NOT medically necessary.