

Case Number:	CM14-0122746		
Date Assigned:	09/25/2014	Date of Injury:	10/09/2013
Decision Date:	11/18/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	08/04/2014

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. The expert reviewer is Board Certified in Emergency Medicine And Fellowship Trained In Emergency Medical Services and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 female who reported an injury on 10/09/2013. The mechanism of injury involved heavy lifting. The current diagnoses include left hip acetabular labral tear, L5-S1 herniated nucleus pulposus, left lower extremity S1 radiculopathy, left sacroiliitis, sleep disorder, hypertension, and gastric complaints. The injured worker was evaluated on 07/11/2014 with complaints of moderate lower back pain radiating into the left lower extremity as well as left hip pain. Previous conservative treatment includes medication management, physical therapy, and hip injections. The physical examination revealed positive Patrick testing on the left, limited left hip range of motion, motor weakness over the left hip flexor motor group, and paresthesia in the left lower extremity. Treatment recommendations at that time included a hip evaluation; home health assistance; a home exercise program; and prescriptions for Voltaren XR 100 mg, Soma 350 mg, Tylenol #3, and compounded creams. A urine drug test was performed on that date and an MRI of the lumbar spine was also requested. A Request for Authorization form was then submitted on 07/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren XR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Diclofenac potassium (Voltaren, Voltaren XR). Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72..

Decision rationale: The California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. There is no strength, frequency, or quantity listed in the request. As such, the request is not medically appropriate.

Soma: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66..

Decision rationale: The California MTUS Guidelines state muscle relaxants are recommended non-sedating second line options for the short term treatment of acute exacerbations. There was no strength, frequency, or quantity listed in the request. As such, the request is not medically appropriate.

MRI lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The Official Disability Guidelines recommends a repeat MRI when there is a significant change in symptoms and/or findings suggestive of significant pathology. The clinical documentation indicated the injured worker had an MRI of the lumbar spine on 04/11/2014. There was a lack of documentation indicating the injured worker had a significant change in symptoms or findings of a significant pathology to support the necessity for a repeat MRI. Given the above, the request for an MRI lumbar spine is not medically appropriate.

Physical therapy lumbar spine: Upheld

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

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

Decision rationale: The California MTUS Guidelines state 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. The treatment for radiculitis is up to 10 sessions. The clinical documentation indicated the injured worker had prior physical therapy. However, there was a lack of documentation of the quantity of prior sessions and the objective functional benefit that was received. Additionally, there was a lack of documented objective functional deficits to support the necessity for supervised therapy. The request was submitted failed to include the quantity of sessions being requested. Given the above, the request for Physical therapy spine is not medically appropriate.

Home health aide: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

Decision rationale: The California MTUS Guidelines recommend home health services only for otherwise recommended medical treatment for patients who are home bound on a part time or intermittent basis, generally up to no more than 35 hours per week. The specific duration of treatment was not listed in the request. There was no indication that this injured worker is home bound. The type of services required were also not listed in the request. As such, the request is not medically appropriate.

X-Force stimulator: Upheld

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

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

Decision rationale: The California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month trial may be considered as a noninvasive conservative option. There was no documentation of an exhaustion of conservative treatment prior to the request for an X force stimulator. There was also no mention of a successful 1 month trial prior to the request for a unit purchase. As such, the request is not medically appropriate.

Solar care FIR heating system: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state at-home local applications of heat or cold are as effective as those performed by a therapist. There is no mention of a contraindication to at-home local applications of heat as opposed to a heating system. Therefore, the request is not medically appropriate.

Kronos lumbar pneumatic brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. There was no documentation of spinal instability or a significant musculoskeletal deficit upon physical examination. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request is not medically appropriate.

Prilosec: 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: Proton Pump Inhibitors (PPIs)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factors and no cardiovascular disease do not require the use of a proton pump inhibitor. Therefore, the injured worker does not meet criteria for the requested medication. There is also no strength, frequency, or quantity listed in the request. As such, the request is not medically appropriate.