MAXIMUS Federal Services

Case Number:	CM14-0140097		
Date Assigned:	10/08/2014	Date of Injury:	07/03/2014
Decision Date:	11/12/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	08/29/2014

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 is licensed to practice in California. 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 25 year-old male, who sustained an injury on July 3, 2014. The mechanism of injury occurred while carrying a sofa on a trailer ramp he slipped and fell. Pertinent diagnostics were not noted. Treatments have included: massage therapy, medications. The current diagnoses are: back contusion, lumbar strain/sprain, lumbosacral neuritis/radiculitis, and back spasm. The stated purpose of the request for 1 back support was not noted. The request for 1 back support was denied on August 25, 2014, citing a lack of documentation of evidence-based guideline support. The stated purpose of the request for 1 TENS unit was not noted. The request for 1 TENS unit was denied on August 25, 2014, citing a lack of documentation of a functional restoration program. The stated purpose of the request for 12 sessions of chiropractic manipulation was not noted. The request for 12 sessions of chiropractic manipulation was modified for 6 sessions on August 25, 2014, noting the necessity of a trial of 6 sessions. The stated purpose of the request for 1 x-ray of the lumbar spine was not noted. The request for 1 x-ray of the lumbar spine was denied on August 25, 2014, citing a lack of documentation of red flag conditions. The stated purpose of the request for Retrospective request for Menthoderm 120gm 4oz DOS: 8/13/14 was not noted. The request for Retrospective request for Menthoderm 120gm 4oz DOS: 8/13/14 was denied on August 25, 2014, citing a lack of documentation of evidence-based guideline support. The stated purpose of the request for Retrospective request for Omeprazole 20mg #60 DOS: 8/13/14 was not noted. The request for Retrospective request for Omeprazole 20mg #60 DOS: 8/13/14 was denied on August 25, 2014, citing a lack of documentation of GI distress symptoms or GI risk factors. The stated purpose of the request for Retrospective request for Naproxen Sodium 550mg #60 DOS: 8/13/14 was not noted. The request for Retrospective request for Naproxen Sodium 550mg #60 DOS: 8/13/14 was denied on August 25, 2014, citing a lack of documentation of a diagnosis of osteoarthritis.

The stated purpose of the request for 1 TPT (Theracane deep pressure massage) was not noted. The request for 1 TPT (Theracane deep pressure massage) was denied on August 25, 2014, citing a lack of documentation of current treatment involving aerobic or strengthening exercise. Per the report dated August 13, 2014, the treating physician noted complaints of lower back pain with radiation to the left thigh. Exam findings included lumbar paraspinal tenderness with spasm and loss of lumbar lordosis, restricted lumbar range of motion, positive left-sided Patrick test, decreased left L5-S1 sensation.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 back support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 300 and 301.

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

Decision rationale: The requested 1 back support is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Low Back Complaints, Page 301, note "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar Supports, also note "Lumbar supports: Not recommended for prevention. Under study for treatment of nonspecific LBP. Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, or post-operative treatment." The injured worker has lower back pain with radiation to the left thigh. The treating physician has documented lumbar paraspinal tenderness with spasm and loss of lumbar lordosis, restricted lumbar range of motion, positive left-sided Patrick test, decreased left L5-S1 sensation. The treating physician has not documented the presence of spondylolisthesis, documented instability, or acute post-operative treatment. The criteria noted above not having been met, 1 back support is not medically necessary.

1 TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic, (transcutanaeous electrical nerve stimulation) Page(s): 114 - 116.

Decision rationale: The requested 1 TENS unit, is not medically necessary. The referenced guidelines note "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration." The injured worker has lower back pain

with radiation to the left thigh. The treating physician has documented lumbar paraspinal tenderness with spasm and loss of lumbar lordosis, restricted lumbar range of motion, positive left-sided Patrick test, decreased left L5-S1 sensation. The treating physician has not documented a current rehabilitation program or functional benefit from electrical stimulation under the supervision of a licensed physical therapist. The criteria noted above not having been met, 1 TENS unit is not medically necessary.

12 sessions of chiropractic manipulation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300,Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: The requested 12 sessions of chiropractic manipulation, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The injured worker has lower back pain with radiation to the left thigh. The treating physician has documented lumbar paraspinal tenderness with spasm and loss of lumbar lordosis, restricted lumbar range of motion, positive left-sided Patrick test, decreased left L5-S1 sensation. The treating physician has not documented the medical necessity for chiropractic sessions beyond the recommended trial of six sessions. The criteria noted above not having been met, 12 sessions of chiropractic manipulation is not medically necessary.

1 x-ray of the 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 ACOEM Guidelines, Chapter 12 (Low back complaints) (2007), pg 308

MAXIMUS 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), Radiography (x-rays)

Decision rationale: The requested 1 x-ray of the lumbar spine is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Low Back Complaints, Special Studies and Diagnostic and Treatment Considerations, Page 303 note "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks;" and Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Radiography (x-rays) note "Radiography (x-rays) - Not recommend routine x-rays in the absence of red flags." The injured worker has lower back pain with radiation to the left thigh. The treating physician has documented lumbar paraspinal tenderness with spasm and loss of lumbar lordosis, restricted lumbar range of motion, positive

left-sided Patrick test, decreased left L5-S1 sensation. The treating physician has not documented applicable red flag conditions. The criteria noted above not having been met, 1 x-ray of the lumbar spine is not medically necessary.

Retrospective request for Menthoderm 120gm 4oz DOS: 8/13/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The requested Retrospective request for Menthoderm 120gm 4oz DOS: 8/13/14 is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has lower back pain with radiation to the left thigh. The treating physician has documented lumbar paraspinal tenderness with spasm and loss of lumbar lordosis, restricted lumbar range of motion, positive left-sided Patrick test, decreased left L5-S1 sensation. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, Retrospective request for Menthoderm 120gm 4oz DOS: 8/13/14 is not medically necessary.

Retrospective request for Omeprazole 20mg #60 DOS: 8/13/14: 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), Pain (Chronic), Proton pump inhibitors (PPIs)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The requested Retrospective request for Omeprazole 20mg #60 DOS: 8/13/14, is not medically necessary. The Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, Pages 68-69, note that "Clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)" and recommend proton-pump inhibitors for patients taking NSAID's with documented GI distress symptoms and/or the above-referenced GI risk factors." The injured worker has lower back pain with radiation to the left thigh. The treating physician has documented lumbar paraspinal tenderness with spasm and loss of lumbar lordosis, restricted lumbar range of motion, positive left-sided Patrick test, decreased left L5-S1 sensation. The treating physician has not documented medication-induced GI complaints or GI

risk factors. The criteria noted above not having been met, Retrospective request for Omeprazole 20mg #60 DOS: 8/13/14 is not medically necessary.

Retrospective request for Naproxen Sodium 550mg #60 DOS: 8/13/14: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287, 288 and 299,Chronic Pain Treatment Guidelines NSAIDs and Naproxen (Naprosyn).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The requested Retrospective request for Naproxen Sodium 550mg #60 DOS: 8/13/14, is medically necessary. The Chronic Pain Medical Treatment Guidelines, Pg. 22, Anti-inflammatory medications note "For specific recommendations, see NSAIDs (non-steroidal anti-inflammatory drugs). 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 injured worker has lower back pain with radiation to the left thigh. The treating physician has documented lumbar paraspinal tenderness with spasm and loss of lumbar lordosis, restricted lumbar range of motion, positive left-sided Patrick test, decreased left L5-S1 sensation. The request for Retrospective request for Naproxen Sodium 550mg #60 DOS: 8/13/14 was denied on August 25, 2014, citing a lack of documentation of a diagnosis of osteoarthritis. However, this NSAID is considered first-line treatment for pain and inflammation. The criteria noted above having been met, Retrospective request for Naproxen Sodium 550mg #60 DOS: 8/13/14 is medically necessary.