

Case Number:	CM14-0170342		
Date Assigned:	10/20/2014	Date of Injury:	02/28/2013
Decision Date:	11/20/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	10/15/2014

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 Family Practice 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:

51 year old female claimant sustained a work injury on 2/28/12 involving the low back, right shoulder and right knee. She was diagnosed with lumbar strain and herniated L4-L5 discs, right shoulder tendonitis and right ankle fracture. She underwent ORIF of the right ankle and surgery for adhesive capsulitis. A progress note on 7/29/14 indicated the claimant had mid back and lumbar pain. Range of motion of the right shoulder was reduced and the right para-scapular region was tender with reduced range of motion. She was to use a moist heat pad for muscle relaxation, continue Motrin for pain, Ambien to aid in sleep and Prilosec for gastrointestinal protection. In addition, 12 sessions of therapy was requested for the right shoulder and back. The claimant had previously completed therapy in March 2014 as well as over 12 sessions in 2013. She had been on Motrin for several months and other NSAIDs as well as Prilosec for over a year.

IMR ISSUES, DECISIONS AND RATIONALES

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

Moist heat pads (refill), quantity 1: 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): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Pain.

Decision rationale: According to the ACOEM guidelines, local heat is optional for at home applications. According to the ODG guidelines, heat therapy is an option and can be helpful in pain reduction. In this case, the claimant's pain is chronic. There is insufficient evidence to support heat in chronic back pain. It is an option but is not medically necessary.

Physical therapy for the lumbar spine and right shoulder, quantity 12: 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 Physical Medicine Page(s): 98-99.

Decision rationale: According to the MTUS guidelines, therapy is recommended in a fading frequency. They allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The following diagnoses have their associated recommendation for number of visits. Myalgia and myositis, unspecified 9-10 visits over 8 weeks, Neuralgia, neuritis, and radiculitis, unspecified, 8-10 visits over 4 weeks Reflex sympathetic dystrophy (CRPS) 24 visits over 16 weeks. The claimant had completed over 12 weeks of physical therapy over the prior year. There is no indication that additional therapy can't be done in a self-guided home exercise plan. The request for 12 additional therapy visits exceeds the amount recommended by the guidelines and is not medically necessary.

Prilosec 20 mg # 45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Nonsteroidal Anti-Inflammatory Drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Nonsteroidal Anti-Inflammatory Drugs) Page(s): 68-69.

Decision rationale: According to the MTUS guidelines, NSAIDs such as Motrin are recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as Acetaminophen, narcotic analgesics, and muscle relaxants. The claimant required the use of Prilosec to protect from the effects of Motrin. The claimant had been on NSAIDs for over a year. Chronic use is not recommended. The continued use of Motrin is not medically necessary.

Motrin 800 mg # 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-steroidal Anti-Inflammatory Drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-steroidal Anti-Inflammatory Drugs) Page(s): 67.

Decision rationale: According to the MTUS guidelines, NSAIDs such as Motrin are recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as Acetaminophen, narcotic analgesics, and muscle relaxants. The claimant required the use of Prilosec to protect from the effects of Motrin. The claimant had been on NSAIDs for over a year. Chronic use is not recommended. The continued use of Motrin is not medically necessary.

Ambien 5 mg # 45: 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) Zolpidem (Ambien)

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

Decision rationale: The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, insomnia medications recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. In this case, the etiology of sleep disturbance is unknown. There is no documentation of behavioral modification. The amount of Ambien provided above is greater than a 10 day supply. Based on the guidelines and lack thorough evaluation of sleep disturbance, the Ambien above is not medically necessary.