

Case Number:	CM14-0020352		
Date Assigned:	05/02/2014	Date of Injury:	05/17/2011
Decision Date:	09/22/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/19/2014

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 Physical Medicine and Rehabilitation, 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 49-year-old female who reported an injury on 05/17/2011. The mechanism of injury was not provided for clinical review. The diagnoses included lumbar myoligamentous injury with lower extremity radicular symptoms, sacroiliac joint dysfunction, and medication induced gastritis. Previous treatments included medication, 12 sessions of physical therapy, and left sacroiliac joint injection. The diagnostic testing included an EMG and MRI. In the clinical note, dated 01/28/2014 it was reported the injured worker complained of pain in the lower back and left hip. She complained of pain in her left sacroiliac joint. Upon the physical examination, the provider noted the injured worker's lumbar musculature had tenderness to palpation bilaterally with increased muscle rigidity. The provider noted the injured worker had numerous trigger points which were palpable and tender, with taut bands throughout the lumbar paraspinal muscles. The range of motion was flexion at 45 degrees and extension at 15 degrees. The provider noted the injured worker had a decrease in sensation along the left lateral calf with use of pinprick wheel. The provider requested physical therapy for gains with range of motion, strength and endurance, Norco, Anaprox, Prilosec, Fexmid and Dendracin topical analgesic cream. However, a rationale was not provided for clinical review. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL PHYSICAL THERAPY X 8: Upheld

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

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

Decision rationale: The request for ADDITIONAL PHYSICAL THERAPY X 8 is not medically necessary. The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, and range of motion. The guidelines allow for fading of treatment frequency plus active self-directed home physical medicine. The guidelines note for neuralgia and myalgia, 8 to 10 visits of physical therapy are recommended. There is a lack of documentation indicating the injured worker's prior course of physical therapy, as well as the efficacy of the therapy. The number of session requested exceeds the guidelines' recommendation of 8 to 10 visits. There is lack of significant objective findings demonstrating the injured worker had decreased functional ability or decreased strength and flexibility. Therefore, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR NORCO: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The RETROSPECTIVE REQUEST FOR NORCO is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider failed to document an adequate and complete pain assessment within the documentation. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication since at least 09/19/2013. Additionally, the request submitted failed to provide the dosage, quantity and frequency of the medication. Therefore, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR ANAPROX: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen, NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 66. 67.

Decision rationale: The RETROSPECTIVE REQUEST FOR ANAPROX is not medically necessary. The California MTUS Guidelines note naproxen, also known as Anaprox, is a nonsteroidal anti-inflammatory drug for the relief of signs and symptoms of osteoarthritis. The guidelines recommend Anaprox at the lowest dose for the shortest period of time in patients with moderate to severe pain. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency, dose and quantity of the medication. Therefore, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR PRILOSEC: Upheld

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

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

Decision rationale: The RETROSPECTIVE REQUEST FOR PRILOSEC is not medically necessary. The California MTUS Guidelines note proton pump inhibitors, such as Prilosec, are recommended for injured workers at risk for gastrointestinal events and/or cardiovascular disease. Risk factors for gastrointestinal events include: over the age of 65; history of peptic ulcer, gastrointestinal bleed or perforation; use of corticosteroids and/or anticoagulants. In the absence of risk factors for gastrointestinal bleeding events, proton pump inhibitors are not indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes stopping the NSAID, switching to a different NSAID, or adding an H2 receptor antagonist or proton pump inhibitor. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Additionally, there is a lack of clinical documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. The request submitted failed to provide the frequency, dosage and quantity of the medication. Therefore, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR FEXMID: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 64.

Decision rationale: The RETROSPECTIVE REQUEST FOR FEXMID is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request as submitted failed to provide the frequency, dosage and quantity of the medication. Additionally, the injured

worker has been utilizing the medication since at least 09/2013, which exceeds the guidelines' recommendation of short-term use of 2 to 3 weeks.

RETROSPECTIVE REQUEST FOR DENDRACIN TOPICAL ANALGESIC CREAM:
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 NSAIDs Page(s): 111-112.

Decision rationale: The RETROSPECTIVE REQUEST FOR DENDRACIN TOPICAL ANALGESIC CREAM is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for the use of osteoarthritis and tendinitis, in particular that of the knee and/or elbow, and other joints that are amenable. Topical NSAIDs are recommended for short-term use of 4 to 12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the quantity, dosage and frequency of the medication. The request submitted failed to provide the treatment site of the medication. Additionally, the injured worker has been utilizing the medication since at least 09/2013, which exceeds the guidelines' recommendation of short-term use of 4 to 12 weeks. Therefore, the request is not medically necessary.