

<b>Case Number:</b>	CM15-0006661		
<b>Date Assigned:</b>	01/21/2015	<b>Date of Injury:</b>	08/22/2011
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	12/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/12/2015

### 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, Arizona

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 54-year-old female who reported an injury on 08/22/2011. The mechanism of injury was the injured worker was trying to lift a client who had fallen. The documentation of 09/19/2014, revealed the injured worker had complaints of neck/headaches radiating to the right upper extremity rated 9/10, and with medication the pain was noted to be 5/10. The injured worker had complaints of low back pain rated 9/10 without medications, and 6/10 with medications. The injured worker had complaints of loss of sleep. The injured worker's grip strength was performed using a Jamar dynamometer revealing 20/30/35 pounds of force on the right, and 10/5/10 pounds of force on the right. The injured worker was noted to be right hand dominant. The injured worker had tenderness and spasm over the neck area, thoracic spine, and lumbar spine, with decreased range of motion. The diagnoses included cervical radiculopathy, cervical sprain and strain, thoracic sprain and strain, lumbar radiculopathy, lumbar sprain and strain, insomnia, and headache. The treatment plan included hydrocodone 5/325 mg, cyclobenzaprine 7.5 mg, and omeprazole 20 mg, as well as compounded topical medications. Additionally, a request was made for a urine drug screen. The injured worker's blood pressure was noted to be 139/93 and pulse was 73 bpm. There was no Request for Authorization submitted to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro: Measure Blood Oxygen Level, DOS 09/19/2014: 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 [www.emedicine.medscape.com/article/2116433-overview#aw2aab6b2b1aa](http://www.emedicine.medscape.com/article/2116433-overview#aw2aab6b2b1aa) accessed 03/17/2015

**Decision rationale:** Per Medscape.com, pulse oximetry is a noninvasive method of measuring the oxygenation level in the blood. It is indicated for injured workers who have respiratory complaints. The clinical documentation submitted for review failed to provide a documented rationale for the requested service. Given the above, and the lack of documentation, the request for retro measure blood oxygen level, DOS 09/19/2014, is not medically necessary.

**Retro: Hand Muscle Testing Manual, DOS 09/19/2014: 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 Low Back Chapter, Flexibility.

**Decision rationale:** The Official Disability Guidelines indicate that flexibility should be part of a routine musculoskeletal evaluation. The clinical documentation submitted for review failed to provide a rationale for the requested muscle testing. There was a lack of documentation indicating the measurement could not be obtained during the routine musculoskeletal evaluation. The request as submitted failed to include the had that was being requested to be tested. Given the above, the request for retro hand muscle testing manual, DOS 09/19/2014, is not medically necessary.

**Retro: Muscle Test One Limb, DOS 09/19/2014: 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 Low Back Chapter, Flexibility.

**Decision rationale:** The Official Disability Guidelines indicate that flexibility should be part of a routine musculoskeletal evaluation. The clinical documentation submitted for review failed to provide a rationale for the requested muscle testing. There was a lack of documentation indicating the measurement could not be obtained during the routine musculoskeletal evaluation. The request as submitted failed to include the limb that was being requested to be tested. Given the above, the request for retro muscle test, 1 limb, DOS 09/19/2014, is not medically necessary.

**Retro: Omeprazole DR 20MG, #60, DOS 09/19/2014: 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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend proton pump inhibitors for injured workers who are at intermediate or high risk for gastrointestinal events. The clinical documentation submitted for review failed to indicate the injured worker was at intermediate or high risk for gastrointestinal events. There was a lack of documentation indicating, if this was the initial prescription, the injured worker was at high risk or intermediate risk. If this was a subsequent prescription, there was a lack of documentation indicating efficacy for the requested medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for retro omeprazole DR 20 mg #60, DOS 09/19/2014, is not medically necessary.

**Retro: Cyclobenzaprine (Flexeril) 75MG, #60, DOS 09/19/2014: Upheld**

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review failed to provide the duration of use. There was a lack of documented efficacy, if the injured worker had utilized the medication previously. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for retro cyclobenzaprine (Flexeril) 75 mg #60, DOS 09/19/2014, is not medically necessary.

**Retro: Hydrocodone (Norco) 5-325MG, #60, DOS 09/19/2014: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of

objective functional improvement, objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had an objective decrease in pain. However, there was a lack of documentation of objective functional improvement. There was documentation the injured worker was being monitored for aberrant drug behaviors through urine drug screens. There was a lack of documentation indicating the injured worker was being monitored for side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for retro hydrocodone (Norco) 5/325 mg #60, DOS 09/19/2014, is not medically necessary.