

Case Number:	CM15-0110462		
Date Assigned:	06/17/2015	Date of Injury:	02/12/2013
Decision Date:	10/05/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	06/08/2015

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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 53-year-old female, who sustained an industrial injury on February 12, 2013. She reported back, left ankle, foot, and right knee pain after getting her foot caught in a cord and falling. The injured worker was diagnosed as having thoracic sprain/strain, lumbar musculoligamentous injury, lumbar muscle spasm, lumbar disc protrusion, lumbar facet hypertrophy, and right knee internal derangement, left foot tenosynovitis, right knee sprain/strain and left foot pain. Treatment to date has included diagnostic studies, radiographic imaging, lumbar epidural steroid injection, conservative care, physical therapy, medications and work restrictions. Currently, the injured worker complains of continued back, left ankle, foot, and right knee pain. The injured worker reported an industrial injury in 2013, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on June 19, 2014, revealed continued pain as noted. Evaluation on February 20, 2014, revealed pain in the right shoulder, elbow, hand, and fingers, mid and low back as well as respiratory problems. Evaluation on December 16, 2014, revealed continued pain as noted. Right knee surgery was discussed and recommended. Evaluation on January 9, 2015, revealed continued pain as noted with lower extremity radiculitis. The home exercise plan was continued. Evaluation on June 16, 2015, revealed continued pain as noted. Medications follow up visits and diagnostic studies were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Omeprazole (Prilosec) 20 MG #90 DOS 5-19-15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines proton pump inhibitor, NSAID, gastrointestinal events Page(s): 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (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. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor Omeprazole. Retro Omeprazole (Prilosec) 20 MG #90 is not medically necessary.

Retro Cyclobenzaprine (Flexeril) 10 MG #60 DOS 5-19-15: 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): 64.

Decision rationale: The Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants. There is no documented functional improvement from any previous use in this patient. The MTUS also state that muscle relaxants are no more effective than NSAID's alone. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. Retro Cyclobenzaprine (Flexeril) 10 MG #60 is not medically necessary.

Menthoderm Cream 120 Gram #1: 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 analgesic Page(s): 111-113.

Decision rationale: Menthoderm Cream is a topical analgesic containing Methyl Salicylate 15.00% and Menthol 10.00%. According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. There is no peer-reviewed literature to support the use of topical Menthoderm Cream. Menthoderm Cream 120 Gram #1 is not medically necessary.

Urine Toxicology Test: 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), UDT.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines urine drug screen Page(s): 43.

Decision rationale: The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. There is no documentation in the medical record that a urine drug screen was to be used for any of the above indications. Urine toxicology Test is not medically necessary.

Follow-Up Visit x 1 with General Medicine in 4-6 Weeks: Upheld

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

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

Decision rationale: The ACOEM guidelines and the Official Disability Guidelines were both reviewed in regards to follow-up visits. Each reference deals primarily with the acute aspects of an injury. The typical timeframe for follow-up visits in a chronic injury is 3-6 months. The patient has chronic pain and has had extensive conservative care with no documented change in symptoms or increase in function over time. The documentation provided for review lacks any specific subjective complaints or objective exam findings for which a follow-up visit would be medically necessary at this time. Follow-Up Visit x 1 with General Medicine in 4-6 Weeks is not medically necessary.

Follow-Up Visit x 1 with Hand Specialist: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic) Follow-up.

Decision rationale: The ACOEM guidelines and the Official Disability Guidelines were both reviewed in regards to follow-up visits. Each reference deals primarily with the acute aspects of an injury. The typical timeframe for follow-up visits in a chronic injury is 3-6 months. The patient has chronic pain and has had extensive conservative care with no documented change in symptoms or increase in function over time. The documentation provided for review lacks any

specific subjective complaints or objective exam findings for which a follow-up visit would be medically necessary at this time. Follow-Up Visit x 1 with Hand Specialist is not medically necessary.

Range of Motion Testing: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy, Quantitative Muscle Testing Devices, Document Number MED.00089, Last Review Date: 11/14/2013.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines do not address quantitative muscle testing devices; consequently, alternative guidelines were used. According to the Blue Cross of California Medical Policy, Quantitative Muscle Testing Devices, Document Number MED.00089, use of quantitative muscle testing devices is considered investigational and not medically necessary. Quantitative muscle testing has been used in clinical research to quantify muscle strength and an individual's response to rehabilitation and therapy. However, manual muscle testing is sufficiently reliable for clinical practice. There is insufficient peer-reviewed published scientific evidence that quantitative muscle testing is superior. Range of Motion Testing is not medically necessary.