

Case Number:	CM15-0175844		
Date Assigned:	09/17/2015	Date of Injury:	10/26/1999
Decision Date:	10/23/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/08/2015

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: 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 57 year old female, who sustained an industrial injury on October 26, 1999. She reported neck, back and right shoulder pain. The injured worker was diagnosed as having cervical sprain and strain, cervical radiculitis and shoulder sprain and strain. Treatment to date has included diagnostic studies, electrodiagnostic studies, home exercise plan, chiropractic care, medications and work restrictions. Currently, the injured worker continues to report neck, back and right shoulder pain, tenderness and decreased range of motion. The injured worker reported an industrial injury in 1999, resulting in the above noted pain. She was without complete resolution of the pain. Electrodiagnostic studies of the bilateral upper extremities on July 30, 2015, revealed chronic versus acute evidence of right sided cervical radiculopathy. Evaluation on August 11, 2015, revealed continued pain as noted. The home exercise plan was discussed and chiropractic care for the neck was certified. She rated her pain at 5 on a 1-10 scale with 10 being the worst. Medications were continued and a magnetic resonance image (MRI) of the neck and right shoulder was recommended. Evaluation on August 20, 2015, revealed continued pain as noted. It was noted she was self-paying for chiropractic care and was "happy with it". She rated her pain at 5 on a 1-10 scale with 10 being the worst. Work restrictions were continued and medications were continued. It was noted she was doing the home exercise plan and using a TENS unit three times daily. She denied side effects from the medications and there was no indication of gastrointestinal problems secondary to medication use. The RFA included requests for Omeprazole 20mg #60 and One MRI of the neck and was non-certified on the utilization review (UR) on August 28, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

One MRI of the neck: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Chapter, under Magnetic resonance imaging (MRI).

Decision rationale: Based on the 6/23/15 progress report provided by the treating physician, this patient presents with neck pain rated 6/10 on VAS scale, right shoulder pain, and pain/numbness radiating down to the right arm/hand. The treater has asked for One MRI of the neck on 7/10/15. The request for authorization was not included in provided reports. The patient is s/p previous C-spine MRI per 6/23/15 report. The patient currently takes Norco 2-3 times a day, reduced from the 4 a day she took since about 1999 per 6/23/15 report. The patient wakes up every 2 hours every night due to low back pain per 6/23/15 report. A prior C-spine MRI dated 9/14/14 showed at C5-6: posterior bulging causing several millimeters encroachment on anterior aspect of the thecal sac. There is 1-2mm of subluxation of C5 anterior on C6. The canal diameter is 11.2mm. Facets show mild degenerative change. No foraminal narrowing is seen. At C6-7: there is posterior spurring and bulging causing several mm encroachment on the anterior aspect of the thecal sac. The canal diameter is 10.8mm. There is no foraminal narrowing. Facets show minimal degenerative change. The patient's work status is unemployed, and treater states "I think we could place her on modified duty with no overhead work" per 6/23/15 report. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, pages 177-178 states: "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." ODG-TWC Guidelines, Neck and Upper Back (Acute & Chronic) Chapter, under Magnetic resonance imaging (MRI) Section states, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." The treater does not discuss this request in the reports provided. The patient had a recent cervical MRI done on 9/14/14. Review of reports dated 12/2/14 to 7/20/15 do not show documentation or discussion of significant change in symptoms or findings since the 2014 MRI. There is no discussion of progression of neurologic deficit, no red flags and no new injury to warrant a repeat MRI study. This request is not in accordance with guideline criteria. Therefore, the request IS NOT medically necessary.

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Based on the 6/23/15 progress report provided by the treating physician, this patient presents with neck pain rated 6/10 on VAS scale, right shoulder pain, and pain/numbness radiating down to the right arm/hand. The treater has asked for Omeprazole 20mg #60 but the requesting progress report is not included in the provided documentation. The patient is s/p previous C-spine MRI per 6/23/15 report. The patient currently takes Norco 2-3 times a day, reduced from the 4 a day she took since about 1999 per 6/23/15 report. The 5/19/15 report also states the patient is taking Ibuprofen. The patient wakes up every 2 hours every night due to low back pain per 6/23/15 report. A prior C-spine MRI dated 9/14/14 showed at C5-6: posterior bulging causing several millimeters encroachment on anterior aspect of the thecal sac. There is 1-2mm of subluxation of C5 anterior on C6. The canal diameter is 11.2mm. Facets show mild degenerative change. No foraminal narrowing is seen. At C6-7: there is posterior spurring and bulging causing several mm encroachment on the anterior aspect of the thecal sac. The canal diameter is 10.8mm. There is no foraminal narrowing. Facets show minimal degenerative change. The patient's work status is unemployed, and treater states, "I think we could place her on modified duty with no overhead work" per 6/23/15 report. MTUS, NSAIDs, GI symptoms & cardiovascular risk section, pg. 68, 69: that omeprazole is recommended with precaution for patients at risk for gastrointestinal events: 1. Age greater than 65. 2. History of peptic ulcer disease and GI bleeding or perforation. 3. Concurrent use of ASA or corticosteroid and/or anticoagulant. 4. High dose/multiple NSAID. NSAIDs, GI symptoms, and cardiovascular risks: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2 receptor antagonist or a PPI. The treater does not discuss this request in the reports provided. The patient is using Prilosec as of 5/19/15 report, which states that the patient takes Omeprazole for heartburn. Utilization review letter dated 8/28/15 denies request as there is no record of GI complaints of GERD. The patient is taking an NSAID as of 5/19/15 report. MTUS allows for prophylactic use of PPI along with oral NSAIDs when appropriate GI risk is present. However, although the treater indicates the medication is used for heartburn, review of reports do not show a diagnosis of gastritis, GERD, or ulcers. The treater has not provided GI risk assessment for prophylactic use of PPI, as required by MTUS. Additionally, the patient is under 65 years of age and there is no indication of concurrent use of ASA, corticosteroids, and/or an anticoagulant. Therefore, the request IS NOT medically necessary.