

Case Number:	CM15-0072356		
Date Assigned:	04/22/2015	Date of Injury:	05/23/2013
Decision Date:	05/20/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/16/2015

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: New York

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease

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 45-year-old male, with a reported date of injury of 05/23/2013. The diagnoses include cervical radiculitis, thoracic spine sprain/strain, thoracic compression fracture, lumbar facet arthropathy, lumbar radiculitis, and lumbar spine strain with multilevel degenerative disc disease, lumbar spondylolisthesis, and bilateral knee sprain/strain. Treatments to date have included an MRI of the lumbar spine, an MRI of the cervical spine, a computerized tomography (CT) scan of the lumbar spine, an x-ray of the lumbar spine, oral medications, an MRI of the left knee, an MRI of the right knee, and cortisone injection in the knee. The progress report dated 03/17/2015 indicates that the injured worker had cervical spine pain, rated 3 out of 10; thoracic spine pain, rated 3 out of 10; lumbar spine pain, rated 3 out of 10; left knee pain, rated 2 out of 10; right knee pain, rated 7-8 out of 10. The objective findings include an antalgic gait, stiff movement, showed difficulty with rising from sitting, an erect posture, and tenderness of the lumbar-sacral spine, bilateral medial joint line, negative bilateral straight leg raise, and crepitus of the bilateral knees. The treating physician requested Prilosec 20mg #30 with one refill, Ultram 50mg #60, and interferential (IF) unit patches replacement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg #30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68 - 69.

Decision rationale: The patient is a 45-year-old male with an injury on 05/23/2013. He had neck, back and bilateral knee pain. Straight leg raising was negative. He has knee crepitus. Prilosec is a proton pump inhibitor (PPI). MTUS guidelines for the use of PPI include age of 65 or greater, history of GI bleed or peptic ulcer disease, or use of anticoagulants. The patient does not meet these criteria and Prilosec is not medically necessary.

Ultram 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78 - 79.

Decision rationale: The patient is a 45-year-old male with an injury on 05/23/2013. He had neck, back and bilateral knee pain. Straight leg raising was negative. He has knee crepitus. MTUS, chronic pain guidelines for continued treatment with opiates require objective documentation of improved functionality with respect to the ability to do activities of daily living or work and monitoring for efficacy, adverse effects and abnormal drug seeking behavior. The documentation provided for review does not meet these criteria. Therefore, the request is not medically necessary.

One (1) IF unit patches replacement: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg (Acute & Chronic) Chapter, Interferential Current Therapy (IFC).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Inferential Current Stimulation Page(s): 118.

Decision rationale: The patient is a 45-year-old male with an injury on 05/23/2013. He had neck, back and bilateral knee pain. Straight leg raising was negative. He has knee crepitus. MTUS, Chronic Pain guidelines note that the inferential unit is not medically necessary; thus, the patches for the use of the unit are also not medically necessary.