

Case Number:	CM15-0091073		
Date Assigned:	05/15/2015	Date of Injury:	02/21/2013
Decision Date:	06/18/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	05/11/2015

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 50 year old female, who sustained an industrial injury on 2/21/2013. She reported acute onset left arm pain and burning sensation to the left shoulder with overhead reaching/pulling activity. She subsequently underwent left shoulder surgery in April 2012. She further reported a trip and fall landing on both knees and sustained injury to the low back, bilateral thigh and bilateral knees. Diagnoses include chronic lumbosacral strain with evidence of a 4mm herniation in the lumbar spine, and left shoulder rotator cuff repair. Treatments to date include physical therapy, joint injection, Norco and Norflex. Currently, she complained of low back pain radiating to the buttocks and lower extremities. She also complained of bilateral knee pain and swelling. Pain was associated with weakness, numbness and tingling in the legs. Pain was rated 8/10 VAS. On 4/8/15, the physical examination documented tenderness with decreased lumbar range of motion. The MRI dated 9/5/14 revealed L4-5 disc protrusion with moderate facet hypertrophy and mild to moderate bilateral neuroforaminal narrowing. The plan of care included physical therapy twice a week for three week for lumbar spine, bilateral selective nerve root epidural injections at L4 with fluoroscopy, Protonix 20mg, #30, and Fexmid 7.5mg #45.

IMR ISSUES, DECISIONS AND RATIONALES

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

Protonix 20mg count #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular risk Page(s): 68-69.

Decision rationale: Protonix medication is for treatment of the problems associated with erosive esophagitis from GERD, or in patients with hypersecretion diseases. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for Protonix namely reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any history, symptoms, or GI diagnosis to warrant this medication. The Protonix 20mg count #60 is not medically necessary and appropriate.

Fexmid 7.5mg count #90: 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): 128.

Decision rationale: Per MTUS Chronic Pain Guidelines on muscle relaxant, Fexmid is not recommended for mild to moderate chronic persistent pain problems including chronic pain (other than for acute exacerbations) due to the high prevalence of adverse effects in the context of insufficient evidence of benefit as compared to other medications. Submitted reports have not demonstrated acute change or progressive clinical deficits to warrant long-term use of a muscle relaxant beyond few weeks for this chronic injury. Submitted reports have not documented extenuating circumstances outside guidelines criteria to support for this continued treatment with a muscle relaxant, Fexmid without demonstrated functional improvement from treatment already rendered. MTUS Guidelines do not recommend long-term use of this muscle relaxant beyond first few weeks of acute treatment for this chronic injury. The Fexmid 7.5mg count #90 is not medically necessary and appropriate.

Bilateral selective nerve root epidural injection L4 and L5 with fluoroscopy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injections, page 46.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with

corroborative findings of radiculopathy); However, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. Submitted reports have not demonstrated any radicular symptoms, neurological deficits or remarkable diagnostics to support the epidural injections. There is no report of acute new injury, flare-up, or red-flag conditions to support for pain procedure. Criteria for the epidurals have not been met or established. The Bilateral selective nerve root epidural injection L4 and L5 with fluoroscopy is not medically necessary and appropriate.

Physical therapy 2 times a week for 6 weeks for lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy 2 times a week for 6 weeks for lumbar spine is not medically necessary and appropriate.