Case Number:	CM16-0232543		
Date Assigned:	12/08/2016	**Date of Injury:**	10/25/2016
Decision Date:	01/12/2017	**UR Denial Date:**	11/29/2016
Priority:	Standard	**Application Received:**	12/02/2016

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: Texas,Ohio
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This case involves a now 58-year-old female with a history of an occupational claim from 10/25/2016. The mechanism of injury is detailed as a fall. The current diagnosis is documented as lumbar spine sprain/strain. Past treatments were noted to include medication and activity modification. Diagnostic studies were noted to include an x-ray of the left ankle, right elbow, left foot, and right wrist, performed on 10/25/2016. During the assessment on 11/14/2016, the patient complained of constant low back pain with repetitive bending, stooping, pushing, and pulling. The patient also reported constant pain in the buttocks with repetitive/prolonged sitting. The patient complained of constant pain in the left shoulder and left foot. The physical examination of the left shoulder revealed limited range of motion. There was a negative Neer's test, Hawkins' test, and Speed's test. The physical examination of the lumbar spine revealed limited range of motion with spasm and guarding. There were no neurological deficits in the lower extremities. The physical examination of the left foot revealed tenderness in the mid dorsal area. The patient's medications were noted to include Norflex, Pepcid, and naproxen. The treatment plan was to continue with the current medication regimen, and request authorization for an x-ray of the pelvis, low back, and left shoulder. A Request for Authorization form was dated 11/14/2016. A prior determination dated 11/29/2016 was found not medically necessary due to no documentation of acute muscle spasm to support the ongoing use of Norflex; no documentation of objective findings to warrant the requested x-ray of the pelvis, lumbar spine, and left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norflex 100mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Muscle relaxants (for pain).

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. The treatment plan was to continue with the Norflex. However, there was a lack of acute muscle spasm noted on physical examination to support ongoing use. Additionally, there was a lack of documentation of objective functional improvement. As such, the request is not medically necessary.

Pepcid 20mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Proton Pump Inhibitors (PPIs).

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. The treatment plan was to continue with the current medication regimen. However, there was a lack of subjective complaints of gastrointestinal events to support ongoing use. Given the above, the request is not medically necessary.

X-ray of the pelvis: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hips & Pelvis Chapter, X-Ray.

Decision rationale: The California MTUS and ACOEM Guidelines do not address. The Official Disability Guidelines recommend x-rays for patients who sustained a severe injury. The treatment plan was to request authorization for an x-ray of the pelvis. However, there was a lack of physical examination findings to suggest a change in the patient's condition to warrant the requested x-ray. As such, the request is not medically necessary.

X-rays of the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM Guidelines state that lumbar spine x-rays should not be recommended in patients with low back pain and the absence of red flags or serious spinal pathology. The treatment plan was to request authorization for an x-ray of the lumbar spine. However, there were no red flags noted on physical examination to support the request. Given the above, the request is not medically necessary.

X-rays of the left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM Guidelines state that routine testing, such as laboratory tests and plane field radiographs of the shoulder are not recommended during the first month to 6 weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion for serious shoulder condition or referred pain. The treatment plan was to request authorization for an x-ray of the left shoulder. However, there were no red flags noted on physical examination to raise suspicion of a serious shoulder condition. As such, the request is not medically necessary.

Physical therapy 2-3 times a week for 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Physical medicine treatment.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion to alleviate discomfort. The treatment plan was to request authorization for physical therapy. However, there was a lack of documentation of objective functional deficits found on physical examination to support the request for physical therapy. Additionally, the requested duration exceeds guideline recommendation. As such, the request is not medically necessary.