MAXIMUS Federal Services

Case Number:	CM13-0047169		
Date Assigned:	12/27/2013	Date of Injury:	04/25/2011
Decision Date:	03/11/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	11/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 applicant is a represented [redacted] employee who has filed a claim for chronic mid back, low back, and neck pain reportedly associated with an industrial injury of April 25, 2011. Thus far, the applicant has been treated with the following: Analgesic medications; topical agents; attorney representation; transfer of care to and from various providers in various specialties; unspecified amounts of chiropractic manipulative therapy; and extensive periods of time off of work, on total temporary disability. In a utilization review report of October 22, 2013, the claims administrator denied a request for ketoprofen gel, denied request a Deprizine oral suspension, denied request for lumbar x-rays, denied a lumbar MRI, approved right and left upper extremity EMG-NCS studies denied a lumbar support, denied a TENS unit, partially certified six sessions of manipulative therapy, certified a hot and cold pack, certified a follow-up visit, and denied lower extremity electrodiagnostic testing. The applicant's attorney later appealed. An earlier clinical progress note of September 26, 2013 is highly templated, difficult to follow, and notable for 5 to /8/10 neck, low back, and mid back pain, moderate-to-severe. The applicant states that the medications are generating appropriate analgesia. There is diminished upper and lower extremity motor strength, secondary to pain. MRI imaging of multiple body parts, x-ray testing, lumbar support, TENS unit, and hot and cold packs are endorsed, while the applicant remains off of work on total temporary disability.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription For Compounded Ketoprofen 20% IN PLO GEL 120 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: As noted on page 112 of the MTUS Chronic Pain Medical Treatment Guidelines, ketoprofen is not recommended for topical application purposes. The unfavorable recommendation on ketoprofen results in the entire compound's carrying unfavorable recommendation, per the page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Accordingly, the request is not certified.

1 prescription for Deprizine 15mg/ml oral suspension 250ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation University of Michigan Health System. Gastroesophageal reflux disease (GERD). Ann Arbor (MI): University of Michigan Health System; 2012 May pg 12

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 71. Decision based on Non-MTUS Citation National Library of Medicine

Decision rationale: While page 69 of the MTUS Chronic Pain Medical Treatment Guidelines does support usage of H2 antagonist such as ranitidine or Zantac in the treatment of NSAID induced dyspepsia, in this case, however, there is no clear description of active signs or symptoms of dyspepsia, reflux, and/or heartburn for which an H2 antagonist such as Deprizine would be indicated. Therefore, the request is likewise not certified.

1 lumbar spine x-rays: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back-Lumbar and Thoracic (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in chapter 12, table 12-8, radiographs of the lumbar spine are "recommended" when there are red flags for fracture, cancer, and/or infection present. In this case, there are no such red flags for fracture, tumor, and/or infection evident or suspected here. The attending provider did not proffer any compelling rationale or narrative to the request for authorization here so as to try and offset the unfavorable ACOEM recommendation. Therefore, the request is likewise not certified.

1 single positional MRI of the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back-Lumbar and Thoracic (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: The MTUS Guideline in ACOEM chapter 12 does not address the topic of positional MRI imaging but does note that unequivocal evidence of neurologic compromise should be evident so as to justify imaging studies in those applicants who did not respond to treatment and who would consider surgery an option. In this case, however it is not clearly stated that the applicant would consider a surgical remedy were it offered to her, nor is there unequivocal evidence of neurologic compromise evident on the most recent office visit. It is further noted that the unfavorable recommendation in ACOEM chapter 12 is echoed by that of the third edition ACOEM Guidelines, which note that positional MRIs as diagnostic procedures as "not recommended" as there are no clearly defined uses for positional MRI imaging of the diagnosis or treatment of patient. For all of these reasons, then, the request is not certified.

1 right upper extremity EMG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: While the MTUS-adopted ACOEM Guidelines in chapter 8 table 8-8 does support EMG testing to clarify a diagnosis of nerve root dysfunction in those individuals in whom disk herniation is suspected preoperatively or before epidural steroid injection therapy, in this case, however, there is no indication that the claimant is intent on pursuing surgical remedy insofar as the cervical spine is concerned. There is no evidence that the applicant is considering epidural steroid injection therapy in the cervical region. Therefore, the request is not certified.

Right upper extremity NCV: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: As noted in the MTUS-adopted ACOEM guidelines in chapter 8, NCS testing may help indentify subtle focal neurologic dysfunction in those applicants with neck or arm symptoms or both, which last greater than three to four weeks. In this case, however, there is no clearly stated suspicion of neurologic dysfunction, either subtle or overt, for which nerve conduction testing would be indicated. The applicant's multifocal pain complaints, issues with spasms, etc., suggest musculoskeletal spine pain as opposed to any over neurologic dysfunction.

While some report that the applicant had diminished motor strength on the most recent office visit, these appear, in large part, to be a function of pain and volition as opposed to representing any neurologic dysfunction, either subtle or overt. The attending provider did not, moreover, proffer any specific rationale, narrative, diagnosis, or differential diagnosis along with the request for authorization. Therefore, the request is not certified owing to lack of supporting information.

1 Left upper extremity EMG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: While the MTUS-adopted ACOEM Guidelines in chapter 8 table 8-8 do recommend EMG testing to clarify diagnosis of nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection therapy, in this case, however, the attending provider did not furnish any compelling rationale or narrative along with the request for authorization. The attending provider did not state that the applicant was intent on pursuing cervical spine epidural injection therapy or was in fact intent on pursuing a surgical remedy. Therefore, the request is not certified.

1 Left upper extremity NCV: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: While the MTUS-adopted ACOEM Guidelines in chapter 8 do support NCV to help identify subtle focal necrologic dysfunction in applicants with neck or arm symptoms, which last greater than three to four weeks, in this case, the attending provider did not clearly state what was suspected or was being tested for. The attending provider did not state whether or not he suspected a cervical radiculopathy, peripheral neuropathy, polyneuropathy, etc. No rationale or narrative was attached to the request for authorization. There is no clear evidence of nerve dysfunction on the most recent office visit, either subtle or overt. Therefore, the request is not certified.

1 LSO Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in chapter 12, lumbar supports are not recommended outside of the acute phase of symptoms relief. In this case, the applicant is well outside of the acute phase of symptom relief (date of the injury April 25, 2011). Ongoing usage of lumbar supports is not recommended or indicated in the chronic pain context. Therefore, the request is not certified.

1 TENS Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

Decision rationale: As noted on the page 116 of the MTUS Chronic Pain Medical Treatment Guidelines purchase of a TENS unit is contingent on completion of a successful one-month trial of the same. In this case, however, there is no evidence that the applicant has previously undergone a successful one-month trial of said TENS unit. Therefore, the request is not certified.

Unknown amount of chiropractic therapy that has been modified to a certification of 6 chiro sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: In this case, the applicant's multifocal pain issues are quite clearly chronic. As noted on page 58 of the MTUS Chronic Pain Medical Treatment Guidelines, one to two sessions of manipulative therapy are recommended in the event of recurrences and/or flare ups of chronic pain in those individuals who demonstrate treatment success by achieving and/or maintaining successful return to work. In this case, however, the applicant did not achieve or maintain return to work despite having completed prior unspecified amounts of manipulative therapy. Continued manipulative therapy is therefore not recommended or indicated in this context, particularly in the unspecified amounts being proposed by the attending provider. Accordingly, the request is likewise not certified, on independent medical review.