

Case Number:	CM13-0059269		
Date Assigned:	12/30/2013	Date of Injury:	06/20/2013
Decision Date:	04/04/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	12/02/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 patient is a 58 year old female who reported an injury on 06/20/2013. The mechanism of injury involved a fall. The patient is currently diagnosed with left hip sprain, discogenic lumbar condition, and left arm and forearm sprain. The patient was seen on 10/20/2013. The patient reported ongoing left upper extremity, low back, and left hip pain. Physical examination revealed limited lumbar range of motion, tenderness to palpation along the hip and groin on the left, mild crepitation with range of motion on the left, mild tenderness along the trochanteric area on the left, full strength to resisted function bilaterally with the exception of hip flexion on the left and extension 5-/5, and tenderness along the facet joints at L3-S1 bilaterally. Treatment recommendations included an MRI of the lumbar spine, bilateral lower extremity EMG and NCV studies, an in-home TENS unit, back brace, a hot and cold wrap, chiropractic treatment 3 times per week for 4 weeks, and a prescription for Vicodin, Motrin, and gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Lumbar MRI between 10/11/2013 and 11/10/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause, including MRI for neural or other soft tissue abnormality. As per the documentation submitted, the patient demonstrated only limited range of motion of the lumbar spine. The patient demonstrated symmetric and bilateral deep tendon reflexes, full strength, and intact sensation. The patient has not exhausted previous conservative treatment prior to the request for an imaging study. The medical necessity has not been established. Therefore, the request is non-certified.

1 EMG/NCV bilateral LE between 10/11/2013 and 11/10/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: California MTUS/ACOEM Practice Guidelines state electromyography, including H-reflex tests, may be useful to identify septal, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. As per the documentation submitted, the patient's physical examination only revealed limited range of motion. The patient demonstrated symmetric and bilateral 2+ deep tendon reflexes, full strength, and intact sensation. The patient has not exhausted conservative treatment prior to the request for an electrodiagnostic study. Based on the clinical information received, the request is non-certified.

1 TENS unit between 10/11/2013 and 11/10/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines, Low Back-Lumbar & Thoracic (Acute).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based TENS trial may be considered as non-invasive conservative option. There is no documentation of this patient's active participation in a functional restoration program. There is no evidence that other appropriate pain modalities have been tried and failed. There was also no documentation of a treatment plan including the specific short and long-term goals of treatment with the unit. Based on the clinical information received, the request is non-certified.

1 Back brace between 10/11/2013 and 11/10/2013: 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 Page(s): 300.

Decision rationale: California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. As per the documentation submitted, the patient has not exhausted conservative treatment prior to the request for a specialty referral. The medical necessity has not been established. Therefore, the request is non-certified.

1 Pain management referral between 10/11/2013 and 11/10/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. As per the documentation submitted, the patient has not exhausted conservative treatment prior to the request for a specialty referral. The medical necessity has not been established. Therefore, the request is non-certified.

21 day rental polar care unit between 10/11/2013 and 11/1/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 298-300.

Decision rationale: California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. At-home local applications of heat or cold are as effective as those performed by therapists. As per the documentation submitted, there is no evidence of a contraindication to at-home local applications of heat or cold as opposed to a motorized unit. Based on the clinical information received, the request is non-certified.

20 Amoxicillin 875mg between 10/11/2013 and 11/10/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 12 (Low Back Complaints) (2007), page 161

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Infectious Disease Chapter, Amoxicillin (Amoxil®).

Decision rationale: Official Disability Guidelines amoxicillin is recommended as first-line treatment for cellulitis and other skin and soft tissue infections. As per the documentation submitted, the patient does not currently meet criteria for the requested medication. As such, the request is non-certified.

120 Topamax 50mg between 10/11/2013 and 11/10/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 161.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-21.

Decision rationale: California MTUS Guidelines state Topamax has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of central etiology. It is considered for use for neuropathic pain when other anticonvulsants have failed. As per the documentation submitted, there is no evidence of neuropathic pain upon physical examination. There is also no documentation of a failure to respond to first-line anticonvulsant medications. Based on the clinical information received, the request is non-certified.

12 Chiropractic therapy sessions between 10/11/2013 and 11/10/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the low back is recommended with a therapeutic trial of 6 visits over 2 weeks. As per the documentation submitted, the patient does demonstrate limited lumbar range of motion. However, the current request for 12 chiropractic therapy sessions exceeds guideline recommendations. As such, the request is non-certified.

1 left hip injection under fluoroscopy between 10/11/2013 and 11/10/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip & Pelvis Chapter, (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip & Pelvis Chapter, Intra-articular steroid hip injection (IASHI)

Decision rationale: Official Disability Guidelines state intra-articular steroid hip injection is not recommended in early hip osteoarthritis, and is currently under study for moderately advanced or severe hip osteoarthritis. As per the documentation submitted, the patient does not maintain a diagnosis of osteoarthritis of the hip. The patient's physical examination only revealed tenderness to palpation with slightly diminished range of motion. Based on the clinical information received and the Official Disability Guidelines, the request is non-certified.

20 Zofran 8mg between 10/11/2013 and 11/10/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Ondansetron, Antiemetic.

Decision rationale: Official Disability Guidelines state Zofran is not recommended for nausea and vomiting secondary to chronic opioid use. Zofran has been FDA-approved for nausea and vomiting secondary to chemotherapy and radiation, and is FDA-approved for postoperative use. The patient does not appear to meet criteria for the requested medication. As such, the request is non-certified.