MAXIMUS Federal Services

Case Number:	CM14-0003026		
Date Assigned:	01/29/2014	Date of Injury:	09/14/2007
Decision Date:	10/01/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/08/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Texas. 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/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 injured worker is a 47 year old male who reported an injury to his neck, mid-back, low back, upper and lower extremities. The clinical note dated 12/28/12 indicates the injured worker complaining of 7/10 pain. Numbness, a pins and needles sensation, as well as radiating pain were identified throughout the cervical region. Range of motion limitations were identified. The initial injury occurred on 09/14/07 when he was struck by a construction truck from behind resulting in multiple injuries. The injured worker also reported a loss of consciousness. The injured worker was immediately brought to the emergency room and examined. The injured worker reported severe levels of pain at multiple areas. The note indicates the injured worker utilizing Tylenol at that time for pain relief. The clinical note dated 02/06/13 indicates the injured worker continuing with neck and low back pain. Radiating pain was identified from the back into the lower extremities. The injured worker also reported numbness and weakness in the left lower extremity. The note indicates the injured worker utilizing Naprosyn and Tizanidine for pain relief as well as Omeprazole. The clinical note dated 11/13/13 indicates the injured worker being recommended for a 1 time saliva DNA test. The clinical note dated 11/13/13 indicates the injured worker continuing with 7-10/10 pain at several areas. The injured worker stated the pain was affecting his sleep hygiene. Upon exam, severe tenderness was identified at the T4 level at the midline. No strength deficits were identified in the extremities. Sensory and reflex testing revealed essentially normal findings. The utilization review dated 12/18/13 resulted in denials for a saliva DNA test, a TENS unit, a topical ointment, and an MRI of the thoracic spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE-TIME SALIVA DNA TESTING: 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 Other Medical Treatment Guideline or Medical Evidence: 1.) Fischbach FT, Dunning MB III, eds. (2009). Manual of Laboratory and Diagnostic Tests, 8th ed. Philadelphia: Lippincott Williams and Wilkins. 2.) Pagana KD, Pagana TJ (2010). Mosby's Manual of Diagnostic and Laboratory Tests, 4th ed. St. Louis: Mosby Elsevier.

Decision rationale: The request for a 1 time saliva DNA test is not medically necessary. No high quality studies are published in peer reviewed literature supporting the safety and efficacy of the use of saliva DNA testing. Therefore, without confirmatory evidence in place, this request is not indicated as medically necessary.

4 WEEKS TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION UNIT RENTAL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Page(s): 114-121.

Decision rationale: The request for a 4 week rental of a transcutaneous electrical nerve stimulation unit is not medically necessary. The documentation indicates the injured worker complaining of pain at several sites. The use of a TENS unit is indicated for injured workers who have completed all conservative treatments and the injured worker has undergone a trial of a TENS unit as well as ongoing conservative treatments. No information was submitted confirming the injured worker's completion of any conservative treatments addressing the injured worker's ongoing complaints of pain. Additionally, it is unclear if the injured worker is continuing with conservative treatments. Furthermore, no information was submitted regarding the injured worker's previous trial of a TENS unit. Given these factors, the request is not indicated as medically necessary.

1 KETOPROFEN / BACLOFEN / CAPSAICIN OINTMENT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESIC,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, this compound cannot be considered as medically necessary as it does not meet established and accepted medical guidelines.

1 MRI OF THORACIC SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, CHAPTER 8(NECK AND UPPER BACK), 177-178

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-5.

Decision rationale: An MRI of the thoracic spine is indicated for injured workers with neurologic deficits associated with the thoracic region. No information was submitted regarding the injured worker's neurologic involvement as sensory, strength, and reflex testing have revealed essentially normal findings. Given this factor, this request is not indicated as medically necessary.