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| Case Number: | CM14-0009312 | | |
| Date Assigned: | 02/14/2014 | Date of Injury: | 06/07/2013 |
| Decision Date: | 06/25/2014 | UR Denial Date: | 01/13/2014 |
| Priority: | Standard | Application Received: | 01/23/2014 |

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 Orthopedic Surgery, 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 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 38 year old male injured on June 7, 2013. The mechanism of injury is described as a rear end auto accident where the injured worker was reaching down just below his seat to adjust it and was rear-ended. A progress note dated December 16, 2013 indicates continued complaints of upper back and low back pain that radiates down the spine. The injured worker denies any numbness or paresthesias. The physical examination documents tenderness to palpation about the cervical paraspinous musculature, and limited cervical range of motion, and negative compression, Spurling's, and distraction test. Normal sensory function of the upper extremities is noted. Examination of the low back documents tenderness over the para lumbar musculature with possible spasm and limited lumbar range of motion. There is a positive straight leg raise test, but sensation and reflexes are intact in the lower extremities. An MRI of the lumbar spine is documented as having been performed on January 4, 2014. This demonstrated broad-based disc bulges at L3-S1 with bilateral neuroforaminal narrowing noted at all 3 levels. The utilization review in question was rendered on January 13, 2014. The reviewer non-certified request for radiographs of the lumbar and cervical spine, Soma, a Transcutaneous Electrical Nerve Stimulation (TENS) unit, and computerized range of motion measurements.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 X-RAY OF THE LUMBAR AND CERVICAL SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES, 2ND EDITION (2004), CHAPTER 8 - NECK AND UPPER BACK COMPLAINTS, 182

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

Decision rationale: The ACOEM Guidelines supports the use of radiographs for the cervical spine for acute symptoms when red flag conditions are present, but does not recommend the use of regression cervical spine for the first 4 to 6 weeks when red flag symptoms are absent. Additionally, with regards to the low back, the ACOEM Guidelines recommends radiographs for acute and subacute conditions when red flag symptoms are present. It is not clear why radiographs are required when an MRI of the lumbar spine was recently obtained and demonstrates multilevel degenerative changes with bilateral neuroforaminal narrowing from L3-S1. As such, the request is considered not medically necessary.

CARISPRODOL 350MG #60: 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, SOMA (CARISOPRODOL),

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Carisprodol (SOMA); Page(s): 29.

Decision rationale: The MTUS Chronic Pain Guidelines recommends against the use of this medication and also notes that it is not intended for long-term use. As such, the request is considered not medically necessary and appropriate.

1 TENS UNIT: 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, TENS - TRANSCUTANEOUS ELECTROTHERAPY,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; TENS unit Page(s): 114-116.

Decision rationale: The criteria for the use of a TENS unit as outlined by the MTUS Chronic Pain Guidelines are not met. Specifically, the clinician does not outline the long and short-term goals for use of this intervention. As such, the request is considered not medically necessary and appropriate.

1 COMPUTERIZED RANGE OF MOTION FROM [REDACTED] WITH PROTOCOLS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, computerized range of motion redirects to flexibility

Decision rationale: The Official Disability Guidelines (ODG) does not support the use of computerized range of motion testing. The ODG indicates testing should be part of a routine muscle skeletal evaluation. As such, the current request is considered not medically necessary and appropriate.