

Case Number:	CM14-0105879		
Date Assigned:	07/30/2014	Date of Injury:	02/28/2014
Decision Date:	08/29/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	07/09/2014

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 Physical Medicine and 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 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 33-year-old male who reported an injury on 02/28/2014. The mechanism of injury was not stated. Current diagnoses include thoracic strain, back pain, and thoracic spine pain. The latest physician's progress report submitted for this review is documented on 04/01/2014. The injured worker presented with complaints of persistent lower back pain with radiation into the lower extremities. The current medication regimen includes ibuprofen and Tizanidine. Physical examination revealed moderate tenderness to palpation, diminished range of motion of the bilateral hips and knees, positive anterior drawer sign, and positive straight leg raising. Treatment recommendations at that time included prescriptions for Tylenol and Tizanidine. It was also noted that the injured worker was awaiting authorization for an MRI.

IMR ISSUES, DECISIONS AND RATIONALES

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

FCMC Cream 120gm, #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113..

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines. Pages 111-113. The Expert Reviewer's decision rationale: The California MTUS Guidelines state, "Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." There is no documentation of a failure to respond to first line oral medication. There is also no frequency listed in the current request. As such, the request is not medically necessary.

Keto Cream 120mg, #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): Page 111-113.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines. Pages 111-113. The Expert Reviewer's decision rationale: The California MTUS Guidelines state, "Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." There is no documentation of a failure to respond to first line oral medication. There is also no frequency listed in the current request. As such, the request is not medically necessary.

MRI of the Cervical Spine, Lumbar Spine and Bilateral Shoulders: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 8, Neck and Upper Back Complaints. Pages 177-179. The Expert Reviewer's decision rationale: The California MTUS/ACOEM Practice Guidelines state, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a 3 to 4 week period of conservative care and observation fails to improve symptoms. Lumbar spine x-rays should not be recommended in patients with low back pain and the absence of red flags for serious spinal pathology. For most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms." As per the documentation submitted, there was no physical examination of the cervical spine. There was also no documentation of a significant musculoskeletal or neurological deficit with regard to the lumbar spine or the bilateral shoulders. As the medical necessity has not been established, the request is not medically necessary.

IF Unit: Upheld

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

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

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines. Pages 117-121. The Expert Reviewer's decision rationale: The California MTUS Guidelines state, "Interferential current stimulation is not recommended as an isolated intervention." There is no quality evidence of the effectiveness except in conjunction with recommended treatments. As per the documentation submitted, there is no mention of a failure to respond to conservative treatment. Additionally, the California MTUS Guidelines state, "if the device is to be used, a 1 month trial should be initiated." There is no documentation of a successful 1 month trial prior to the request for a unit purchase. As such, the request is not medically necessary.

Urine Drug Screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77, and 89.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines. Pages 43, 77 and 89. And on the Non-MTUS Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing. The Expert Reviewer's decision rationale: The California MTUS Guidelines state, "Drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs." The Official Disability Guidelines state, "The frequency of urine drug testing should be based on documented evidence of risk stratification. As per the documentation submitted, there is no evidence of noncompliance or misuse of medication. There is also no indication that this injured worker falls under a high risk category that would require frequent monitoring. Therefore, the medical necessity has not been established. As such, the request is not medically necessary.