

Case Number:	CM14-0113314		
Date Assigned:	08/01/2014	Date of Injury:	11/20/2013
Decision Date:	09/15/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/21/2014

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 & Rehabilitation 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:

According to the records made available for review, this is a 46-year-old male with an 11/20/13 date of injury. At the time (5/19/14) of request for authorization for MRI lumbar spine and Trial Ketoprofen Cream, there is documentation of subjective (neck pain radiating down the left arm with numbness, low back pain radiating down to the toes) and objective (tenderness to palpation over the cervical, thoracic, and lumbar paraspinals bilaterally with decreased range of motion, decreased sensation in the right C6-C8 dermatomes and left C5 dermatome, decreased sensation throughout the left lower extremity, decreased strength of the right deltoid, positive bilateral Slump test, and positive lumbar facet challenge) findings, imaging findings (MRI of the lumbar spine (11/30/13) report revealed no significant spinal canal or neuroforaminal narrowing at any level; and small posterior disk bulge at L4-5 and L5-S1), current diagnoses (cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, lumbar radiculopathy, and lumbar facet arthropathy), and treatment to date (physical therapy and medications (morphine and Meloxicam)). Regarding MRI lumbar spine, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings).

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine:

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back, MRI's.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Other Medical Treatment Guidelines: Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

Decision rationale: The MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of lumbar sprain/strain, lumbar radiculopathy, and lumbar facet arthropathy. In addition, there is documentation of a previous lumbar MRI performed on 11/30/13. However, despite documentation of subjective (low back pain radiating down to the toes) and objective (tenderness to palpation over the lumbar paraspinals bilaterally with decreased range of motion, decreased sensation throughout the left lower extremity, and positive lumbar facet challenge) findings, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for MRI lumbar spine is not medically necessary.

Trial Ketoprofen Cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics (NSAIDs) Page(s): 111-112.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies that Ketoprofen is not currently FDA approved for topical application, as it has an extremely high incidence of photocontact dermatitis. Therefore, based on guidelines and a review of the evidence, the request for Trial Ketoprofen Cream is not medically necessary.

