

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0125565 | | |
| Date Assigned: | 08/11/2014 | Date of Injury: | 03/18/2014 |
| Decision Date: | 09/16/2014 | UR Denial Date: | 07/25/2014 |
| Priority: | Standard | Application Received: | 08/04/2014 |

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 38 year old male who sustained an injury on 03/18/14. The mechanism of injury is undisclosed. The injured worker was being followed for complaints of neck pain, mid back pain, and low back pain with numbness and tingling associated to the right upper extremity and left lower extremity. No clinical documentation submitted other than prior utilization review from 07/25/14. The requested MRI of the cervical spine, thoracic spine, and lumbar spine as well as electrodiagnostic studies of the upper extremities and lower extremities, internal medicine consult, Menthoderm, Cyclobenzaprine, Hydrocodone, physical therapy for eight sessions, transcutaneous electrical nerve stimulation (TENS) unit, and functional capacity evaluation were denied by utilization review on 07/29/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official disabilities guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175-177.

Decision rationale: In regards to the request for MRI of the cervical spine, this request is not medically appropriate. There was no clinical documentation for any conservative treatment to date; a limited amount of clinical information is available for review. It was unclear what the current physical examination findings were as no clinical records other than the prior utilization review were available for review. Given the paucity of clinical information available for review for this injured worker this would not support the proposed request. Therefore, this request of MRI cervical spine is not medically necessary and appropriate.

MRI thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official disabilities guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175-177.

Decision rationale: There was a limited amount of clinical information for this injured worker. There was no clinical documentation for any conservative treatment to date. It was unclear what the current physical examination findings were as no clinical records other than the prior utilization review were available for review. Given the paucity of clinical information available for review for this injured worker this would not support the proposed request. In regards to the request for MRI of the thoracic spine, this request of MRI thoracic spine is not medically necessary and appropriate.

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official disabilities guidelines.

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

Decision rationale: There was a limited amount of clinical information for this injured worker. There was no clinical documentation for any conservative treatment to date. It was unclear what the current physical examination findings were as no clinical records other than the prior utilization review were available for review. Given the paucity of clinical information available for review for this injured worker this would not support the proposed request. Therefore, the request of MRI of lumbar spine is not medically necessary and appropriate.

EMG/NCV bilateral upper extremities and bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238. Decision based on Non-MTUS Citation Official disabilities guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 175-177; 305-307.

Decision rationale: In regards to the request for electromyography and nerve conduction velocity (EMG/NCV) studies of the upper and lower extremities, this request is not medically appropriate. There was a limited amount of clinical information for this injured worker, nor any clinical documentation for any conservative treatment to date. It was unclear what the current physical examination findings were as no clinical records other than the prior utilization review were available for review. Given the paucity of clinical information available for review for this injured worker this would not support the proposed request. Therefore, the request of EMG/NCV (Electromyography / Nerve Conduction Velocity) of bilateral upper extremities and bilateral lower extremities is not medically necessary and appropriate.

Menthoderm 360 gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111. Decision based on Non-MTUS Citation <http://www.drugs.com/edi/menthoder-cream.html>.

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

Decision rationale: In regards to the request for Menthoder 360 grams, this request is not medically appropriate. There was a limited amount of clinical information for this injured worker. There was no clinical documentation for any conservative treatment to date. It was unclear what the current physical examination findings were as no clinical records other than the prior utilization review were available for review. Given the paucity of clinical information available for review for this injured worker this would not support the proposed request. Therefore, the request of Menthoder 360 grams is not medically necessary and appropriate.

Cyclobenzaprine 5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63. Decision based on Non-MTUS Citation Official disabilities guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-67.

Decision rationale: In regards to the request for Cyclobenzaprine 5 milligrams quantity ninety, this request is not medically appropriate. There was a limited amount of clinical information for this injured worker. There was no clinical documentation for any conservative treatment to date. It was unclear what the current physical examination findings were as no clinical records other than the prior utilization review were available for review. Given the paucity of clinical information available for review for this injured worker this would not support the proposed

request. Therefore, the request of Cyclobenzaprine 5mg #90 is not medically necessary and appropriate.

Hydrocodone/APAP 2.2/325mg qty #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs. Decision based on Non-MTUS Citation Official disabilities guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 88-89.

Decision rationale: In regards to the request for Hydrocodone 2.2/325 milligrams quantity ninety, this request is not medically appropriate. There was a limited amount of clinical information for this injured worker. There was no clinical documentation for any conservative treatment to date. It was unclear what the current physical examination findings were as no clinical records other than the prior utilization review were available for review. Given the paucity of clinical information available for review for this injured worker this would not support the proposed request. Therefore, the request of Hydrocodone/APAP 2.2/325mg #90 is not medically necessary and appropriate.

Eight (8) Physical therapy visits: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disabilities guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: In regards to the request for physical therapy for eight sessions, this request is not medically appropriate. There was a limited amount of clinical information for this injured worker. There was no clinical documentation for any conservative treatment to date. It was unclear what the current physical examination findings were as no clinical records other than the prior utilization review were available for review. Given the paucity of clinical information available for review for this injured worker this would not support the proposed request. Therefore, the request of Eight (8) Physical therapy visits is not medically necessary and appropriate.

TENS (transcutaneous electrical nerve stimulation) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114, 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 113-117.

Decision rationale: In regards to the request for a transcutaneous electrical nerve stimulation (TENS) unit, this request is not medically appropriate. There was a limited amount of clinical information for this injured worker. There was no clinical documentation for any conservative treatment to date. It was unclear what the current physical examination findings were as no clinical records other than the prior utilization review were available for review. Given the paucity of clinical information available for review for this injured worker this would not support the proposed request. Therefore, the request of TENS (transcutaneous electrical nerve stimulation) unit is not medically necessary and appropriate.

Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disabilities guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, functional capacity evaluation.

Decision rationale: In regards to the request for a functional capacity evaluation, this request is not medically appropriate. There was a limited amount of clinical information for this injured worker. There was no clinical documentation for any conservative treatment to date. It was unclear what the current physical examination findings were as no clinical records other than the prior utilization review were available for review. Given the paucity of clinical information available for review for this injured worker this would not support the proposed request. Therefore, the request of Functional capacity evaluation is not medically necessary and appropriate.

Internal medicine consult for insomnia: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disabilities guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page(s) 32.

Decision rationale: In regards to the request for internal medicine consult, this request is not medically appropriate. There was a limited amount of clinical information for this injured worker. There was no clinical documentation for any conservative treatment to date. It was unclear what the current physical examination findings were as no clinical records other than the prior utilization review were available for review. Given the paucity of clinical information available for review for this injured worker this would not support the proposed request. Therefore, the request of Internal medicine consult for insomnia is not medically necessary and appropriate.