MAXIMUS Federal Services

Case Number:	CM14-0035889		
Date Assigned:	06/23/2014	Date of Injury:	03/28/2009
Decision Date:	07/22/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	03/24/2014

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 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 61-year-old female who reported an injury on 03/28/3009. The mechanism of injury, history, examination, diagnoses, diagnostic studies, surgeries and procedure, and treatments were not provided within the documentation. The medications were Cyclobenzaprine HCL 7.5 mg, Hydrocodone-APAP 10-325 mg, and Zolpidem Tartrate 10 mg. The requested treatment included retrospective intramuscular injection of Toradol 2ml (Date of Service: 2/14/14), one (1) electric stamper, chiropractic therapy for the lumbar spine, eight (8) visits, and chiropractic therapy for the cervical spine, eight (8) visits. There was no clinical information submitted from the requesting provider to indicate the rationale for the request or the previous courses of treatment. The request for authorization form was not provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR INTRAMUSCULAR INJECTION OF TORADOL 2ML (DATE OF SERVICE: 02/14/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, specific drug list and adverse effects Page(s): 72.

Decision rationale: The injured worker's mechanism of injury was not provided within the documentation. The Chronic Pain Guidelines indicate that Ketorolac (Toradol, generic available): is not indicated for minor or chronic painful conditions. There was no clinical information submitted from the requesting provider to indicate the rationale for the request or the previous courses of treatment. As such, the request for retrospective request for intramuscular injection of Toradol 2ml (Date of Service: 2/14/14) is not medically necessary.

ONE (1) ELECTRIC STAMPER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpel Tunnel Chapter, Ergonomic Interventions.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg, Durable medical equipment.

Decision rationale: The injured worker's mechanism of injury was not provided within the documentation. According to the Official Disability Guidelines, the term durable medical equipment (DME) is defined as equipment which can withstand repeated use, could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. There was no clinical information submitted from the requesting provider to indicate the rationale for the request or the previous courses of treatment. In addition, an electric stamper would not serve a primarily medical purpose. Therefore, the request does not fall within the definition of durable medical equipment according to the guidelines. As such, the request for one (1) electric stamper is not medically necessary.

EIGHT (8) CHIROPRACTIC THERAPY VISITS FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-59.

Decision rationale: The injured worker's mechanism of injury was not provided within the documentation. The Chronic Pain Guidelines indicate that manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. There was no clinical information submitted from the requesting provider to indicate the rationale for the request or the previous courses of treatment. As such, the request for chiropractic therapy for the lumbar spine, eight (8) visits is not medically necessary.

EIGHT (8) CHIROPRACTIC THERAPY VISITS FOR THE CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-59.

Decision rationale: The injured worker's mechanism of injury was not provided within the documentation. The Chronic Pain Guidelines indicate that manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. There was no clinical information submitted from the requesting provider to indicate the rationale for the request or the previous courses of treatment. As such, the request for chiropractic therapy for the cervical spine, eight (8) visits is not medically necessary.