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| Case Number: | CM14-0090042 | | |
| Date Assigned: | 07/23/2014 | Date of Injury: | 01/19/2014 |
| Decision Date: | 09/26/2014 | UR Denial Date: | 06/04/2014 |
| Priority: | Standard | Application Received: | 06/14/2014 |

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 67 year old female who reported an injury to her low back. The initial injury occurred on 01/19/14 when the injured worker stood too close to another person when they turned around a pushed her on her side. The clinical note dated 03/24/14 indicates the injured worker complaining of low back pain. The injured worker was able to demonstrate full range of motion; however, flexion was identified as exacerbating her pain. The note indicates the injured worker utilizing Celebrex and Cyclobenzaprine for pain relief. The note does indicate the injured worker having been recommended for physical therapy at that time. The clinical note dated 04/08/14 indicates the injured worker continuing with thoracic region back pain. The injured worker rated the pain as 5-6/10. The note does indicate the injured worker having initiated physical therapy which was providing some benefit. The clinical note dated 05/29/14 indicates the injured worker able to demonstrate 30 degrees of lumbar and thoracic flexion with 10 degrees of extension, and 10 degrees of bilateral lateral bending. Decreased sensation was identified in the L4, L5, and S1 dermatomes on the right. Strength deficits were also identified throughout the right lower extremity. There was also an indication the injured worker has a positive straight leg raise at 40 degrees as well. The utilization review dated 06/04/14 resulted in a denial for electrodiagnostic studies and labs as insufficient information had been submitted supporting these requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidopro Topical Ointment 4oz #1: 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 Page(s): 111.

Decision rationale: The safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, MTUS, Food and Drug Administration, and the Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore this compound cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Chiropractic 1 Visit per Week x 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

Decision rationale: The documentation indicates the injured worker complaining of low back pain. A total of 4 sessions of chiropractic therapy are recommended and with an objective functional improvement, additional sessions are to be provided. However, no information was submitted regarding the injured worker's previous trial of chiropractic manipulation. Therefore, this request is not medically necessary.

EMG Bilateral Lower Extremities: Upheld

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

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

Decision rationale: There is an indication the injured worker has neurologic deficits in the right lower extremity. However, no information was submitted regarding the injured worker's neurologic involvement in the left lower extremity. Therefore, the request is not medically necessary.

NCS Bilateral Lower Extermities: 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 Chapter, Nerve conduction studies (NCS).

Decision rationale: There is an indication the injured worker has neurologic deficits in the right lower extremity. However, no information was submitted regarding the injured worker's neurologic involvement in the left lower extremity. Therefore, the request is not medically necessary.

Labs-CMP x1: 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 Other Medical Treatment Guideline or Medical Evidence: 1.)Fischbach FT, Dunning MB III, eds. (2009). Manual of Laboratory and Diagnostic Tests, 8th ed. Philadelphia: Lippincott Williams and Wilkins.2.)Pagana KD, Pagana TJ (2010). Mosby's Manual of Diagnostic and Laboratory Tests, 4th ed. St. Louis: Mosby Elsevier.

Decision rationale: No information was submitted regarding the need for lab studies in order to provide the injured worker with sufficient treatment. Therefore, this request is not indicated as medically necessary.