

Case Number:	CM14-0090488		
Date Assigned:	07/23/2014	Date of Injury:	05/10/2009
Decision Date:	08/28/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/16/2014

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 68 year old female who had a work related injury on 05/10/09 while working and tripped and fell over some computer wiring. The injured worker complained of bilateral knee pain and thoracolumbar spine pain. Approximately six months after her accident she began treatment with a chiropractor. Along with chiropractic manipulative therapy, the injured worker had serial electrodiagnostic studies and quantitative functional capacity evaluation. The injured worker underwent left knee arthroscopy, agreed medical examination with orthopedic specialists and internal medicine specialist. There has been no clinical documentation of functional improvement with the chiropractic treatment. No documentation of lumbar radiculopathy. On physical examination range of motion of the lumbar spine and bilateral knees were decreased. Crepitus, point tenderness, myospasm. Positive ortho neuro testing, including paresthesia under the distal lower extremities and weakness. Prior utilization review on 06/04/14 non-certified the 1x4 in house on as needed basis, approved follow up visit with ortho, denied set of three injections, and denied dermatology referral and updated EMG/NCV of lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

1x4 in house with [REDACTED] on an as needed basis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chronic Pain Treatment Guidelines Post surgical treatment.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 298-299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, Manipulation.

Decision rationale: The clinical documentation submitted for review does not support the request. The injured worker has been under chiropractic care for greater than 4 years, and there has been no documentation of functional improvement. Therefore, request for 1x4 chiropractic treatment on an as needed basis is not medically necessary and appropriate.

Set of 3 injections with Ortho [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, Epidural steroid injections, "series of three".

Decision rationale: The clinical documentation submitted for review as well as current evidence based guidelines do not support the request. The injured worker has no documented signs of lumbar radiculopathy. Epidural steroid injections, series of three. Not recommended. Original recommendations that suggested a series of three injections generally did so prior to the advent of fluoroscopic guidance. These previous recommendations were based primarily on case studies and anecdotal evidence. There does not appear to be any evidence to support the current common practice of a series of injections. Therefore, the request for set of 3 injections with Ortho [REDACTED] is not medically necessary and appropriate.

Dermatology referral to [REDACTED] for skin irritation: 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: The Palliative Care Handbook, Guidelines for clinical management and symptom control 7th edition.

Decision rationale: The clinical documentation does not support the request. There has been no documentation of medical necessity for any dermatologic problems. Therefore, the request for dermatology referral to [REDACTED] for skin irritation is not medically necessary and appropriate.

EMG/NCV of the LE on 2/20/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, EMGs (electromyography) Nerve conduction studies (NCS).

Decision rationale: The clinical documentation submitted for review does not support the request. The injured worker has no documented signs of lumbar radiculopathy. The injured worker has had several electrodiagnostic studies since her injury, to monitor her progress. Therefore, the retrospective request for EMG/NCV testing of the lower extremity on 2/20/2014 is not medically necessary and appropriate.