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| Case Number: | CM14-0095830 | | |
| Date Assigned: | 07/25/2014 | Date of Injury: | 04/20/2004 |
| Decision Date: | 08/28/2014 | UR Denial Date: | 06/04/2014 |
| Priority: | Standard | Application Received: | 06/24/2014 |

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in New York and 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 46 year old female who had a work related injury on April 20, 2004. Mechanism of injury was not documented. Most recent submitted medical record dated April 12, 2014 the injured worker was seen with a history of chronic back pain who presented with a fall. She was status post rod implantation in her lower lumbar spine and spinal cord stimulator. Physical examination the injured worker was alert, no acute distress. Palpation along musculature of lower lumbar spine. Spinal cord stimulator incision noted. No midline bony step off or deformities. Neurologically, reflexes were normal, speech was normal motor strength was intact. Medications Lasix, Lisinopril, Effexor, Wellbutrin diagnosis chronic back pain. Prior utilization review on June 4, 2014 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prologel 6oz bottle: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical Analgesics.

Decision rationale: The current evidence based guidelines do not support the request. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. As such medical necessity has not been established. The request for Prologel 6oz bottle is not medically necessary.