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| Case Number: | CM14-0192719 | | |
| Date Assigned: | 11/26/2014 | Date of Injury: | 02/03/2008 |
| Decision Date: | 01/28/2015 | UR Denial Date: | 10/27/2014 |
| Priority: | Standard | Application Received: | 11/18/2014 |

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 Family Practice, and is licensed to practice in New Jersey & New York. 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 female who was injured on 2/3/08 where her wrists were twisted by a patient. She complained of right wrist pain with numbness and tingling. She also sustained a slip and fall onto her buttocks on 2/4/09. She complains of lower back pain. On exam, she had normal heel/toe walk, normal reflexes of lower extremities, sensory deficit of right L1-S2 dermatomes, and decreased range of motion of lumbar spine. A 9/2014 electrodiagnostic test showed severe sensory motor peripheral polyneuropathy due to multilevel lumbosacral radiculopathy. She was diagnosed with neck and lumbar sprain/strain, lower back pain with bilateral lower extremity radiculopathy, lumbar facet joint syndrome, displacement of lumbar intervertebral disc without myelopathy and right wrist/hand carpal tunnel syndrome. She used a TENS unit with improvement. Her medications included tramadol, anti-inflammatory and medication for gastritis. She had four lumbosacral spine epidural steroid injections which helped temporarily. The current request is for urinalysis for toxicology, ortho shockwave for cervical and lumbar spine, and chiro-physiotherapy for the cervical and lumbar spine which were denied by utilization review on 10/27/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urinalysis for toxicology: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing, Opioids. Page(s): 43 and 78.

Decision rationale: The request for a urine drug screen is considered medically necessary. Her medications included Tramadol which is considered an opioid and in order to monitor effectively, the 4 A's of opioid monitoring need to be documented. This includes the monitoring for aberrant drug use and behavior. One of the ways to monitor for this is the use of urine drug screens. The UR states the patient was not on opioid analgesics but she was on Tramadol so it is reasonable to monitor with urine drug screens. Therefore, I am reversing the prior UR decision and consider this request to be medically necessary.

Ortho shockwave for CS and LS: 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) Lower back, shock wave therapy

Decision rationale: The request is not medically necessary. MTUS guidelines did not address the use of shock wave therapy for cervical and lumbar spine. Therefore, ODG guidelines were used. As per ODG, "the available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged." Therefore, the request is considered not medically necessary.

Chiro-physiotherapy 3 x 4 to the CS and LS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request is considered not medically necessary. The patient has received previous chiropractic and physical therapy sessions without documentation of the gains in pain control and improvement in functional capacity. There should be objective documentation of improvement to continue with additional therapy sessions. Because the outcome of prior therapy was not documented, the request is considered not medically necessary.