

Case Number:	CM15-0003989		
Date Assigned:	01/15/2015	Date of Injury:	02/27/2014
Decision Date:	03/24/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/08/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 53-year-old male who reported an injury on 02/27/2014. The diagnosis was sprain of neck. The mechanism of injury was the injured worker lifted a patient. The injured worker underwent an MRI of the lumbar spine. Prior therapies were not provided. The injured worker underwent electrodiagnostic studies. The worker underwent an MRI of the lumbar spine with flexion and extension. Therapies included extracorporeal shock wave therapy. The injured worker underwent manual therapy. The documentation of 11/11/2014 revealed the injured worker had complaints of frequent, severe neck aches and a neck that was sore, tight, and the pain was sharp. The injured worker complained of constant, severe low backaches. Objective findings revealed decreased range of motion and pain in all planes. The injured worker had a positive foraminal compression and Jackson compression bilaterally. There was tenderness to palpation over the upper trapezius, rhomboids, and levator scapulae bilaterally. The injured worker had decreased range of motion of the lumbar spine and pain in all planes. The injured worker had tenderness to palpation over the quadratus lumborum, erector spinae, latissimus dorsi, SI joints, gluteus, and biceps femoris bilaterally. There was a positive Kemp's, Bechtrew's, Elys, and iliac compression test bilaterally. The injured worker was noted to undergo an MRI of the cervical spine and lumbar spine. The diagnoses included cervical and lumbar sprain and strain with multilevel IVD, radiculitis, and myofasciitis. The treatment plan included continue with pain management and medications, continue with orthopedic surgeon, continue with home stretching and exercise, provide Synovacin and Dendracin for topical use and joint health. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro prolong office visit/service: 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, Office visit.

Decision rationale: The Official Disability Guidelines indicate the need for a clinical office visit with a health care provider is individualized based upon review of the injured worker's concerns, signs and symptoms, and clinical stability. The clinical documentation submitted for review failed to provide the requested date of service. There was a lack of documentation indicating the specialist that was to be utilized. There was a lack of documentation indicating a need for a prolonged office visit. Given the above, and the lack of documentation, the request for retro prolong office visit/service is not medically necessary.

Retro pulse oximetry: 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: <http://emedicine.medscape.com/article/2116433-overview#aw2aab6b2b1aa> accessed 03/17/2015

Decision rationale: Per Medscape.com, pulse oximetry is utilized when there is documentation of respiratory complaints of asthma or respiratory complaints. The clinical documentation submitted for review failed to provide the requested date of service. There was a lack of documented rationale for the pulse oximetry. Given the above, the request for retro pulse oximetry is not medically necessary.

Retro Muscle testing: 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, Flexibility.

Decision rationale: The Official Disability Guidelines indicate that flexibility examinations should be part of a routine musculoskeletal evaluation. There was a lack of documentation indicating the date for the requested muscle testing. There was a lack of documented rationale indicating a necessity for a separate evaluation for the muscle testing. The muscles to be tested were not provided. Given the above, the request for retro muscle testing is not medically necessary.

Retro Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. The clinical documentation submitted for review failed to provide the requested date of service. There is a lack of documentation of objective functional benefit, if previously utilized and the duration of use could not be established. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for retro cyclobenzaprine 7.5 mg #60 is not medically necessary.