MAXIMUS Federal Services

Case Number:	CM15-0004050		
Date Assigned:	01/15/2015	Date of Injury:	02/27/2014
Decision Date:	03/23/2015	UR Denial Date:	12/16/2014
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
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 electrodiagnostic studies of the lower extremities. Prior therapies were not provided. The worker underwent an MRI of the lumbar spine with flexion and extension. Therapies included extracorporeal shock wave therapy and chiropractic care. The documentation of 10/15/2014 revealed the injured worker had subjective complaints of low back pain radiating to the bilateral lower extremities, right greater than left. The injured worker had pain of an 8/10 on the VAS without medication and 6/10 with medication. The injured worker complained of neck pain and headache radiating to the bilateral upper extremities, left greater than right. The pain was rated a 6/10 on the VAS without medications and a 5/10 with medications. The injured worker's blood pressure was 152/85 and the pulse was 72 beats/minute. The cervical spine examination revealed tenderness and spasms over the cervical spinal area with decreased range of motion. The injured worker had tenderness and spasms in the lumbar spine area with decreased range of motion. The diagnoses included headache, cervical radiculopathy, cervical sprain/strain, lumbar radiculopathy, lumbar sprain/strain and insomnia. The treatment plan included medications, hydrocodone 5/325 mg for pain control, Anaprox 550 mg for inflammation, cyclobenzaprine 7.5 mg for muscle spasms, omeprazole 20 mg as a prophylactic gastro protectant, topical compound creams, psychosocial evaluation, and a follow-up with the primary care physician for blood pressure issues. 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: pulse oximetry DOS: 10/15/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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. 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: Hand muscle testing manual DOS: 10/15/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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 laterality of the hand to be tested was not provided. Given the above, the request for Retro: Hand muscle testing manual DOS: 10/15/2014 is not medically necessary.

EMG/NCS-one limb DOS: 10/15/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The American College of Occupational and Environmental Medicine indicate that for most injured workers presenting with true neck or upper back problems, special studies are not needed unless 3 to 4 week period of conservative care and observation fails to

improve symptoms. They further indicate that electromyography and nerve conduction velocities, including age reflex tests, may help identify subtle focal neurologic dysfunction in injured workers with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. The request as submitted failed to indicate the specific body part to be tested for the EMG and NCS. Additionally, there was a lack of documentation of objective findings upon physical examination to determine which body part testing was being requested. The injured worker had undergone lower extremity testing. Given the above, and the lack of clarification, the request for EMG/NCS-one limb DOS: 10/15/2014 is not medically necessary.

Retro: Cyclobenzaprine (flexeril) 7.5mg #60 DOS: 10/15/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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. 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 (Flexeril) 7.5mg #60 DOS: 10/15/2014 is not medically necessary.

Retro: prolonged service office visit DOS: 10/15/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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. 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: prolonged service office visit DOS: 10/15/2014 is not medically necessary.