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| Case Number: | CM15-0045886 | | |
| Date Assigned: | 03/18/2015 | Date of Injury: | 05/14/2014 |
| Decision Date: | 04/23/2015 | UR Denial Date: | 02/20/2015 |
| Priority: | Standard | Application Received: | 03/10/2015 |

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

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 was a 52 year old male, who sustained an industrial injury, May 14, 2014. The injured worker previously received the following treatments physical therapy, EMG/NCV (electromyography/nerve conduction velocity studies), chiropractic services, laboratory studies, cervical spine MRI, x-ray orbits and cardio-respiratory diagnostic testing. The injured worker was diagnosed with cervical spine sprain/strain; rule out cervical spine degenerative dis disease, right shoulder sprain/strain, rule-out right shoulder internal derangement, cervical spine multi-level disc herniations and cervical spine radiculitis mild on the right. According to progress note of January 22, 2015, the injured workers chief complaint was neck and right shoulder pain. The physical exam noted muscle tenderness of the cervical spine, and right shoulder. There was decreased range of motion to the cervical spine and right shoulder with positive impingement, occipital tenderness, shoulder depression and distraction. The treatment plan included an autonomic nervous system function test on January 15, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Autonomic nervous system function test: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Autonomic nervous system function testing.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: The ACOEM Chapter 8 on neck and shoulder indicates that specialized treatments or referrals require a rationale for their use. According to the documents available for review, the patient appears to have previously undergone the requested testing. There is no rationale provided as to why a repeat exam would be needed. Therefore, at this time the requirements for treatment have not been met, and medical necessity has not been established.

TGIce cream #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the MTUS, there is little to no research to support the use of topical compounded creams. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Topical analgesics are largely experimental and there are a few randomized controlled trials to determine efficacy or safety. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.

Flurbiprofen 20% cream #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the MTUS, there is little to no research to support the use of topical compounded creams. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Topical analgesics are largely experimental and there are a few randomized controlled trials to determine efficacy or safety. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.