

Case Number:	CM14-0161877		
Date Assigned:	10/07/2014	Date of Injury:	09/16/2007
Decision Date:	02/06/2015	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	10/02/2014

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 California. 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:

This injured worker is a 51-year-old male with a date of injury reported 09/16/2007. The mechanism of injury was a burn to the left thumb and shortly after the injury he developed bacterial endocarditis with systemic sepsis, stroke and renal failure. His prior treatments have included the use of a back brace, aquatic therapy, and psychiatric therapy. His diagnoses include cervical spine strain/sprain, right shoulder strain/sprain, lumbar spine strain/sprain, mitral valve incompetence, cephalgia with myofascial pain syndrome, status post fracture of L4 and left rib cage in 2000, status post fracture of right wrist, fibromyalgia, anxiety and depression, fractured fibula, right ankle status post pedestrian versus motor vehicle accident, 11/15/2013. Diagnostic studies included an MRI in 11/26/2012 which showed a herniated nucleus pulposus at C3-4, C4-5, C5-6 and C6-7 and the same MRI showed lumbar spine herniated nucleus pulposus at L3-4, L4-5. The injured worker presented on 08/06/2014 with complaints of bilateral shoulder pain, cervical pain and low back pain with radicular symptoms in the upper and lower extremities. Physical examination performed showed right shoulder flexion to 130 degrees, abduction to 120 degrees and extension to 30 degrees with positive subacromial grinding and clicking. There is tenderness with palpation over the greater tuberosity of the humerus and over the paraspinal musculature. Deep tendon reflexes are +2 for the knees and +1 for the ankles. His current medications are Xanax, trazodone, Zoloft, Norco, Percocet, metoprolol, Lyrica, Wellbutrin, Abilify, Ativan, Ambien, gabapentin, aspirin and Prozac and durations of over a year. The treatment plan was to refill the medications, add Percocet and re-evaluate the patient in 4 weeks. The request is for chromatography and there was no rationale given for the request. The Request for Authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chromatography: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Integrated Treatment/ Disability Duration 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 Preoperative testing, general.

Decision rationale: worker presented with pains, bilateral shoulder pain, cervical spine pain and low back pain. Chromatography is the collective term for a set of laboratory techniques for the separation of mixtures. The Official Disability Guidelines state lab investigations can be helpful to stratify risk but often are obtained because of protocol rather than medical necessity. The decision to order tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. The medical records as provided lacked documentation for the treatment that would require the use of chromatography. The physician did not document any discussion of the chromatography services. The documentation as provided did not indicate any specific details with regard to functional improvement, improvement in work function or in activities of daily living. As such, the request for chromatography is not medically necessary.