

Case Number:	CM15-0127177		
Date Assigned:	07/20/2015	Date of Injury:	09/24/2014
Decision Date:	10/06/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	07/01/2015

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: Utah, Arkansas

Certification(s)/Specialty: Family Practice, Sports Medicine

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 50-year-old male, who sustained an industrial injury on 9/24/14. The injured worker has complaints of back and left leg radicular pain. The documentation noted range of motion creates discomfort in both flexion and extension and positive straight leg raise on the left. The documentation noted there is decreased sensation in the left thigh. The diagnoses have included lumbar disc herniation and lumbar sprain and strain. Treatment to date has included electromyography/nerve conduction study on 4/29/15 was normal; chiropractic care; brace; anti-inflammatories; oral steroid and epidural corticosteroid injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 3 x 4 thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page(s) 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck/upper back chapter.

Decision rationale: MTUS guidelines state the following: Manual Therapy and Manipulation recommendations. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended: Low back: Recommended as an option. ODG recommends up to 18 sessions of chiropractors with evidence of objective functional improvement after 6 sessions. Chronicity should be avoided. The current request exceeds the recommended amount of sessions prior to documentation of objective functionality. According to the clinical documentation provided and current MTUS guidelines; Chiropractic manipulative treatment, as written above, is not medically necessary to the patient at this time.

Functional Improvement Measurement with measure: 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); Fitness for Duty), Functional Capacity Evaluations (FCE).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page 49.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Functional Improvement Program. The clinical records lack documentation that the patient has undergone a functional capacity evaluation to define objective goals. According to the clinical documentation provided and current MTUS guidelines; a Functional Improvement Program is not medically necessary to the patient at this time.

MRI thoracic spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page 305.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for MRI of the back. MTUS guidelines state the following: Despite the lack of strong medical evidence supporting it, discography, including MRI, is fairly common, and when considered, it should be reserved only for patients who meet the following criteria: Back pain of at least three months duration. Failure of conservative treatment. Satisfactory results from detailed psychosocial assessment. (Discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided.) Is a candidate for surgery. Has been briefed on potential risks and benefits from discography and surgery. The clinical documents lack documentation that the patient has met these criteria. According to the clinical documentation provided and current MTUS guidelines; MRI, as written above, is not medically necessary to the patient at this time.

Localized Intense Neurostimulation Therapy 1 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 120 and 121.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter.

Decision rationale: MTUS treatment guidelines do not specifically discuss the spine stimulator. The request is for Neurostimulation Therapy. Official Disability Guidelines state very specific guidelines for an implanted stimulator. This includes but is not limited to, Failed Back syndrome, realistic expectations of procedure, no substance abuse, no contraindications, and permanent placements requires evidence Neurostimulation is considered ineffective in treating nociceptive pain. There is no documentation of a psychological evaluation that states that the pain is not psychological for the patient. There is also no documentation that states there are no contraindications for this particular surgery. According to the clinical documentation provided and current guidelines; the requirements for the Neurostimulation Therapy have not been met.

Therefore, it is not medically necessary to the patient at this time.

Neurosurgery Spine Consultation: 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 General Approach to Initial Assessment and Documentation, page 22,Independent Medical Examinations and Consultations, chapter 7.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Neurosurgery consultation. MTUS guidelines state the following: consultation is indicated, when there are "red flag" findings. Also, to aid in the diagnosis, prognosis, therapeutic management, and determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. According to the clinical documentation provided and current MTUS guidelines; Neurosurgery consultation is medically necessary to the patient at this time.

Psychologist Consultation: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations Page(s): 100 and 101.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines General Approach to Initial Assessment and Documentation, page 22,Independent Medical Examinations and Consultations, chapter 7.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Psychologist consultation. MTUS guidelines state the following: consultation is indicated, when there are "red flag" findings. Also, to aid in the diagnosis, prognosis, therapeutic management, and determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work.

According to the clinical documentation provided and current MTUS guidelines; Psychologist consultation is medically necessary to the patient at this time.

Hot/Cold pack: Overturned

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

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

Decision rationale: MTUS does not specifically mention a cold therapy unit, but does recommend at-home applications of heat and cold and would support hot and cold packs for acute pain. According to the clinical documentation provided and current MTUS guidelines; Cold/Heat Pack are indicated. Therefore the request is medically necessary to the patient at this time.

Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10%: 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 Page 41.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for a Topical Compound. The MTUS states gabapentin is not recommended as a topical analgesic. Therefore, according to the guidelines cited, it cannot be recommended at this time. The request for the compounded medication is not medically necessary.

Cyclobenzaprine 2%, Flurbiprofen 25%: 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: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Topical Analgesics. The MTUS guidelines discuss compounding medications. The guidelines state that a compounded medicine, that contains at least one drug (or class of medications) that is not recommended, is not recommended for use. The guidelines also state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Therefore, according to the guidelines cited, it can not be recommended at this time. The request for Topical Analgesics is not medically necessary.