

Case Number:	CM13-0002562		
Date Assigned:	07/25/2013	Date of Injury:	02/05/2013
Decision Date:	01/08/2014	UR Denial Date:	07/10/2013
Priority:	Standard	Application Received:	07/22/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine, Pulmonary Diseases, 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 physician 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:

The patient is a 50-year-old female who reported an injury on 02/05/2013 due to a slip and fall, injuring her right neck and shoulder and left knee. Following the injury, the patient was provided with medications, a course of physical therapy, and modified work duty. It was noted that the patient's current status at that time was performing her normal and customary job duties. The patient had persistent neck and upper extremity pain. Physical findings included cervical paraspinal tenderness and mild muscle spasms and right shoulder tenderness about the biceps tendon, as well as the acromioclavicular joint. It was noted that the patient had supraspinatus and impingement maneuvers that produced pain. The patient was diagnosed with cervical strain with bilateral upper extremity radiculitis, right shoulder impingement syndrome with acromioclavicular joint pain, and bilateral wrist contusions. The patient's treatment plan included medications, physical therapy, and evaluation for an ergonomic work station.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ergonomic work station evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 125-126.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175-176, Chronic Pain Treatment Guidelines Page(s): 125-126. Decision

based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness For Duty Chapter, Modified duty & return to work,.

Decision rationale: The requested ergonomic work station evaluation is not medically necessary or appropriate. The clinical documentation does identify that the patient continues to have shoulder and neck complaints. CA MTUS/ACOEM states adjustment or modification of workstation, job tasks or work hours and methods are supported methods of symptom control. The clinical documentation submitted for review does indicate that the patient is working full duty without restrictions. The need for an ergonomic evaluation is not clearly identified within the documentation. The documentation does not provided any evidence that the patient's work station is exacerbating her symptoms as she is able to work full duty without restrictions. It is noted within the documentation that the patient works throughout the day without difficulty as long as breaks are taken. As such, the requested ergonomic work station evaluation is not medically necessary or appropriate.

Xoten-c lotion #120: Upheld

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

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

Decision rationale: The requested Xoten-C lotion #120 is not medically necessary or appropriate. The patient does have continued pain complaints of the neck and shoulder. The requested medication contains Capsaicin. California Medical Treatment Utilization Schedule does not recommend topical analgesics as they are largely experimental and are not supported by scientific evidence. Additionally, medications that include the compound of Capsaicin are only supported when the patient has failed to respond to first line treatments. The clinical documentation does not indicate that the patient is unable to tolerate oral analgesics. As such, the requested Xoten-C lotion #120 is not medically necessary or appropriate.

Physical therapy, neck and right shoulder #8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Page(s): 98-99.

Decision rationale: The requested physical therapy; eight (8) sessions, neck and right shoulder are not medically necessary or appropriate. The patient does continue to have pain complaints and range of motion deficits related to the cervical and shoulder area. However, California Medical Treatment Utilization Schedule recommends the patient be instructed in a home exercise program and transitioned out of supervised physical therapy. The clinical documentation submitted for review does provide evidence that the patient already underwent a normal course

fo physical therapy. The patient should be well-versed in a home exercise program. Additionally, it is noted that the patient participated in 2 additional physical therapy sessions recently. There are no barriers noted within the documentation to preclude further progress of the patient while participating in a home exercise program. Additionally, there are no exceptional factors noted within the documents to extend treatment beyond guideline recommendations. As such, the requested physical therapy; eight (8) sessions, neck and right shoulder are not medically necessary or appropriate.

Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine. .

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41.

Decision rationale: The requested cyclobenzaprine 7.5 MG #60 is not medically necessary or appropriate. The patient does have continued neck and shoulder complaints. California Medical Treatment Utilization Schedule does not support the use of Cyclobenzaprine 7.5 mg in the use of chronic pain management. This type of medication is only recommended for a short course of treatment. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. Therefore, continuation of treatment with this medication is not supported. As such, the requested cyclobenzprine 7.5 MG #60 is not medically necessary or appropriate.