

Case Number:	CM13-0008176		
Date Assigned:	12/18/2013	Date of Injury:	04/27/2007
Decision Date:	03/05/2014	UR Denial Date:	07/15/2013
Priority:	Standard	Application Received:	08/07/2013

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 Orthopedic Surgery 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 62-year-old male who reported an injury on 12/31/2007 due to cumulative trauma while performing normal job duties. The patient reportedly injured the cervical spine, lumbar spine and bilateral wrists. Prior treatments included chiropractic care, massage therapy, physical therapy, medications, shockwave therapy, a TENS unit and psychiatric support. The patient's most recent clinical examination revealed that the patient complained of continued low back pain radiating into the lower extremities and continued neck pain radiating into the upper extremities, rated at a 5/10 to 6/10 with medications and a 7/10 without medications. The patient was regularly monitored for aberrant behavior with urine drug screens. Objective findings included tenderness to the spinal vertebral process from the L4-S1 with myofascial tenderness in the lumbar region upon palpation. The patient's diagnoses included lumbar radiculopathy, lumbar disc degeneration, lumbar facet arthropathy, myalgia/myositis, osteoarthritis of the knee and right knee chondromalacia. The patient's treatment plan included the continuation of a home exercise program, myofascial release, the use of Voltaren and a followup visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

One follow up visit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter, section on Office Visits.

Decision rationale: The clinical documentation submitted for review does indicate that the patient is seeing multiple specialists. The Official Disability Guidelines recommend followup visits for patients who require ongoing treatment. The clinical documentation does indicate that the patient has a chronic condition and is taking medications that require regular monitoring. However, as the documentation indicates that the patient is seeing multiple doctors, the outcome of these other visits would need to be established to determine the need for a followup visit with a pain management specialist. As such, the requested followup visit between 06/28/2013 and 09/19/2013 is not medically necessary or appropriate.

Voltaren GEL XT 1%: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines do recommend the use of this medication for short courses of treatment. However, the clinical documentation submitted for review does indicate that the patient is primarily being treated for back pain. Although Voltaren gel is recommended as a topical nonsteroidal anti-inflammatory drug, it is not recommended by the MTUS Chronic Pain Guidelines for use in pain related to the spine. There is little scientific evidence to support the efficacy of this medication for spine pain. Therefore, the use of Voltaren gel XT 1% between 06/28/2013 and 09/01/2013 is not medically necessary and appropriate

Unknown myofascial release: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

Decision rationale: The clinical documentation submitted for review does indicate that the patient has previously undergone massage therapy. The MTUS Chronic Pain Guidelines do recommend the use of massage therapy in the management of chronic pain. However, the continuation of treatment must be based on functional benefit and pain relief. The clinical documentation does not adequately address the patient's functional benefit or pain relief resulting from previous therapy. Therefore, continued therapy would not be supported. As such, the requested myofascial release between 06/28/2013 and 09/01/2013 is not medically necessary or appropriate.