MAXIMUS Federal Services

Case Number:	CM13-0015378		
Date Assigned:	10/07/2013	Date of Injury:	06/06/2012
Decision Date:	01/14/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	08/22/2013

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 Diseasesand 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 36 year old male who reported an injury on 06/06/2012, the mechanism of injury was not provided. His initial diagnosis is unclear as is his primary course of treatment. It is noted, however, that the patient received epidural steroid injections and physical therapy, body region, quantity, and efficacy unknown, as well as 8 sessions of acupuncture to date. The most recent clinical note dated 06/18/2013 reported the patient h ad a normal gait, minimal range of motion deficits in the cervical spine, moderate range of motion deficits in the lumbar spine, and pain, tenderness, and spasm to both areas on palpation. His shoulders and extremities were normal, grip strength was greate r on the right than the left, motor strength and neurological function was intact throughout. At this time, the patient was diagnosed with lumbar spine displaced without radiculopathy; lumbar facet syndrome; lumbar degenerative disc disease; lumbar strain/ sprain; cervical disc without radiculopathy, cervical degenerative disc disease; cervical strain/sprain, and insomnia. A complete list of current medications was not provided, however, there was note that the patient was prescribed Anaprox DS 550mg, Omepra zole 20mg, Hydrocodone 10/550mg, Soma 250mg, Cartivisc 500/200/150mg, Colox 750mg, Toprophan, and Exoten - C pain relief lotion, frequencies, efficacy, and length of use not specified

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture Bilateral knees, bilateral shoulders, bilateral forearms 1 x 4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California MTUS Guidelines recommend ac upuncture as an optional treatment for chronic pain if functional improvement is documented. Functional improvement as defined by MTUS includes significant measurable improvement in activities of daily living or a reduction in work restrictions. The patien t already received approximately 8 sessions of acupuncture with no documentation of efficacy, to include measurable functional improvements. Guidelines state that the time to produce functional improvement is 3 - 6 visits, which has already been exceeded by the patient. Furthermore, there is no documentation or diagnoses provided in the medical records noting to injuries or complaints of the shoulder, bilateral knees, or bilateral forearms. Therefore, the 4 additional sessions of acupuncture are non - certified.

Chiropractic treatments to bilateral knees, bilateral shoulders, bilateral forearms 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): s 58-60.

Decision rationale: The California MTUS Guidelines recommend chiropractic care as an option to treat musculoskeletal pain. The goal of treatment is to achieve symptomatic and objective measurable gains in functional improvement to facilitate progression in the patient's therapeutic exercise program and return to pr oductive activities. The records provided for review do not support any diagnoses or objective findings related to injuries of the bilateral shoulders, bilateral knees, or bilateral forearms. The patient also offered no complaints regarding these areas as noted in the clinical notes provided. Furthermore, guidelines do not recommend manual manipulation to the forearms or knees. Due to the lack of subjective complaints and objective findings related to injuries of the bilateral shoulders, bilateral knees, an d bilateral forearms, the request for 8 sessions of chiropractic care are non - certified.

Ibuprofen 800mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti - inflammatory medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines non - steroidal anti - inflammatory drugs (NSAID)'s Page(s): s 67-72.

Decision rationale: The California MTUS Guidelines state that for acute back pain and exacerbations of chronic back pain, non - steroidal anti - inflammatories should be a second line treatment after acetaminophen. In regard to chronic low back pain, non - steroidal anti -

inflammatory drugs (NSAID)'S's are recommended for short term symptomatic relief due to the multiple adverse Final Determination Letter for IMR Case Number [redacted] effects caused by NSAID use. MTUS states that Ibuprofen dosing for mild to moderate pain should not ex ceed 400mg every 4 - 6 hours as needed, as doses higher than 400mg have not produced greater pain relief. The medical records reviewed did not state the intended duration or past efficacy of this drug. Nor did they provide any information regarding a trial u se of acetaminophen with objective record of its efficacy. Furthermore, there is no documentation of either subjective complaints or objective findings as they relate to pain or injuries of the bilateral shoulders, knees, and forearms. As such, the request for Ibuprofen 800mg for bilateral shoulders, knees, and forearms is non - certified

Topical compound cream (Tramadol, Flurbiprofen) 800mg: Upheld

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 Topical Analgesics Page(s): s 111-112.

Decision rationale: California MTUS guidelines state that topical analgesics are primarily recommended to treat neuropathic pain after primary and secondary treatments have failed. Non - neuropathic indications for topical NSAID use include osteoarthritis and tendinitis, in par ticular, that of the knee and elbow or other joints that are amenable to topical treatment. There is also little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Due to the lack of subjective complaints or o bjective findings related to diagnoses or injuries of the bilateral shoulders, forearms, or knees, the request is non - certified.