

Case Number:	CM13-0027622		
Date Assigned:	09/08/2014	Date of Injury:	05/09/1995
Decision Date:	10/16/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	09/23/2013

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 Orthopedic Spine Surgeon and is licensed to practice in Texas. 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:

The injured worker is a 64-year-old male who reported an injury on 05/09/1995 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to the bilateral knees. It was noted that the injured worker ultimately underwent bilateral total knee replacements. The injured worker developed chronic pain that was managed with medications. The injured worker was evaluated on 07/07/2014. The physical findings included decreased range of motion of the cervical spine with decreased motor strength of the bilateral upper extremities and decreased sensation in the C5, C6, C7, and C8 dermatomal distributions bilaterally. the examination of the lumbar spine documented tenderness to palpation and decreased range of motion secondary to pain, a positive Kemp's test bilaterally, and decreased sensation in the L4, L5, and S1 nerve root distributions. The evaluation of the bilateral shoulders documented restricted range of motion secondary to pain with 4/5 motor strength and positive Neer's, impingement, and Hawkins signs bilaterally. The evaluation of the bilateral knees documented tenderness to palpation over the medial and lateral joint lines with a positive varus and valgus test bilaterally. the injured worker's diagnoses included cervical disc disease, status post cervical fusion, lumbar disc disease, bilateral knee replacement with chronic pain, bilateral shoulder sprain/strain, and bilateral ankle sprain/strain. A request was made for Biotherm topical cream, and MRI of the left shoulder, a consultation with a podiatrist, and a consultation with a hand surgeon. No request for authorization was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bio-Therm Topical Cream 4oz: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Topical Analgesics, 111-113

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

Decision rationale: The requested Biotherm topical cream 4 ounces is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the use of topical analgesics unless the patient has failed to respond to first line medications to include anticonvulsants and antidepressants. The clinical documentation submitted for review does not provide any indication that the injured worker is unable to tolerate oral medications and has failed to respond to first line medications. Additionally, the request as it is submitted does not provide a frequency of treatment or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Biotherm topical cream 4 ounces is not medically necessary or appropriate.

Physical Therapy 2 X Week for 6 Weeks, Cervical and Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physical Medicine

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

Decision rationale: The California Medical Treatment Utilization Schedule recommends up to 10 visits of physical therapy for radicular, neuropathic, and myofascial pain. The clinical documentation submitted for review does support that the injured worker has previously participated in physical therapy for the cervical and lumbar spine. The California Medical Treatment Utilization Schedule recommends that patients be transitioned into a home exercise program to maintain improvement levels obtained during skilled physical therapy. There is no documentation that the injured worker is currently participating in a home exercise program. Therefore, 1 to 2 visits would be indicated in this clinical situation to re-educate and re-establish a home exercise program. However, the requested 12 visits would be considered excessive. There were no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested physical therapy 2 times a week for 6 weeks for the cervical and lumbar spine not medically necessary or appropriate.