

Case Number:	CM13-0034214		
Date Assigned:	12/06/2013	Date of Injury:	04/25/2010
Decision Date:	01/14/2014	UR Denial Date:	09/18/2013
Priority:	Standard	Application Received:	10/11/2013

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 <MPR BRD CERT>, has a subspecialty in <MPR SUBSPEC CERT> and is licensed to practice in <MPR ST LICENSE>. 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.

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 56-year-old female who reported an injury on 04/25/2010 after tripping and falling forward reportedly causing injury to her knee and head. The patient was initially treated with anti-inflammatory medications, knee brace immobilizers and crutches, and physical therapy. The patient sustained an additional fall following an incident causing her knee to buckle. The patient developed low back pain as a result of this fall. The patient underwent a lumbar MRI that revealed a disc bulge at the L3-4, L4-5, and L5-S1 levels, and evidence of moderate to severe right-sided and mild to moderate left-sided neural foraminal narrowing at the L4-5 level. The patient continued to be treated with medications and used a wheeled walker with a seat to assist with ambulation. The patient's medications included topical Motrin and tramadol. The patient's most recent exam findings include low back pain complaints rated at 7/10 to 9/10 radiating into her left lower extremity with complaints of bilateral lower extremity weakness. Physical findings revealed restricted lumbar range of motion described as 40 degrees in flexion, 5 degrees in extension, 10 degrees in right lateral bending, and 5 degrees in left lateral bending. The patient had a positive straight leg raising test on the right. The patient's diagnoses included lumbar spine pain with moderate degenerative changes, pelvic pain, bilateral knee pain and internal derangement. The patient's treatment plan included continuation of medication usage, use of an infrared heat lamp, and chiropractic care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motrin cream 60mg, quantity 2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) , Low Back-Lumbar & Thoracic..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Topical Analgesics Page(s): 60 and 111.

Decision rationale: The Physician Reviewer's decision rationale: The requested Motrin cream 60 mg Qty 2 is not medically necessary or appropriate. The patient does have continued pain complaints in the bilateral knees and low back. California Medical Treatment Utilization Schedule does not support the use of topical nonsteroidal anti-inflammatory agents unless patients are intolerant of oral anti-inflammatory agents. The clinical documentation submitted for review does not indicate that the patient cannot tolerate oral anti-inflammatory agents. Additionally, California Medical Treatment Utilization Schedule states that the use for medications for chronic pain must be supported by increased functional benefit and an assessment of pain relief. The clinical documentation submitted for review does not provide any evidence that the patient is receiving any functional benefit or pain relief as a result of this medication. Therefore, continuation cannot be supported. As such, the request for the use of Motrin cream 60mg, quantity of 2 is not medically necessary and appropriate.

SolarCare FIR heating system, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) , Low Back-Lumbar & Thoracic. .

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

Decision rationale: The Physician Reviewer's decision rationale: The requested [REDACTED] is not medically necessary or appropriate. The patient does have pain complaints of the low back and bilateral knees. California Medical Treatment Utilization Schedule states "passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process." The clinical documentation submitted for review does not provide any evidence that the patient is participating in any active therapy that would benefit from the use of the combination of passive therapy treatments. Therefore, the request to purchase [REDACTED] is not medically necessary and appropriate.

Chiropractic treatment for lumbar spine number of visits not specified: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) , Low Back-Lumbar & Thoracic..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy.

Decision rationale: The requested chiropractic treatment for the lumbar spine is not medically necessary or appropriate. The patient does have continued pain complaints and range of motion deficits of the lumbar spine. California Medical Treatment Utilization Schedule does recommend a trial of 6 visits of chiropractic care for therapeutic management of low back pain. Additional visits must be supported by objective functional improvement. The request as written does not provide frequency or duration or the number of visits to allow for reassessment of objective functional improvement. As such, the request for chiropractic treatment for lumbar spine number of visits not specified is not medically necessary and appropriate.