MAXIMUS Federal Services

Case Number:	CM13-0035575		
Date Assigned:	12/13/2013	Date of Injury:	01/06/2009
Decision Date:	02/21/2014	UR Denial Date:	10/14/2013
Priority:	Standard	Application Received:	10/17/2013

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 and Cardiology, has a subspecialty in Cardiovascular Disease 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 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 60 year old male who reported a work-related injury on 01/06/2009; mechanism of injury was noted as strain to the bilateral upper extremities and cervical spine. The clinical note dated 10/23/2013 reports the patient was seen under an orthopedic consultation by provider, [redacted]. The provider documents the patient underwent arthroscopic decompression of the right shoulder on 07/14/2012. The patient reports she utilizes Gabapentin, Cymbalta, and Naproxen. The provider documents the patient has utilized physical therapy which increased her symptomatology. The patient reports pain starts from the top of the shoulder and radiates down to the fingertips which worsens with movement of the neck. The provider documents the patient has supraclavicular and infraclavicular swelling and tenderness, brachial plexus neural tension signs were positive (i.e., radial, ulnar, and median nerve neural tension signs were positive); increased with contralateral neck bending. The patient's cervical spine range of motion was well per the provider, but with lateral rotation and bending, the patient had decreased painful motion to the left. The provider documents the patient's bilateral upper extremities have range of motion within normal limits, as well as motor strength. The provider felt the patient's presenting diagnoses were brachial plexitis. The provider recommended physical therapy specifically directed at brachial plexus. The clinical note dated 12/06/2013 reports the patient was seen under the care of [redacted] who documents the patient is a surgical candidate for her lumbar spine pathology.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multidisciplinary evaluation of functional restoration program: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 31-32.

Decision rationale: The current request is not supported. The clinical documentation submitted for review evidences shows the patient continues to present with moderate bodily injury pain complaints status post a work-related injury sustained over 5 years ago. The clinical notes document the patient is a possible surgical candidate for her lumbar spine symptomatology. Additionally, an evaluation dated 10/23/2013 recommended physical therapy interventions specifically utilized for diagnoses of brachial plexitis. Given the lack of documentation evidencing exhaustion of lower levels of conservative care prior to the request for participation in chronic pain management program as recommended via California Medical Treatment Utilization Schedule (MTUS) Guidelines, the request for multidisciplinary evaluation of functional restoration program is not medically necessary or appropriate

Voltaren 1% gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: The current request is not supported. The clinical documentation submitted for review fails to provide evidence that the patient's reports of efficacy with utilization of this topical analgesic as noted by a decrease in rate of pain on a visual analog pain scale and increase in objective functionality. California Medical Treatment Utilization Schedule (MTUS) indicates Voltaren gel is supported for relief of osteoarthritis pain in joints that lend themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. The patient's primary complaints are about the cervical spine, lumbar spine, and shoulder. Given all of the above, the request for Voltaren 1% gel is not medically necessary or appropriate.