

Case Number:	CM13-0037568		
Date Assigned:	12/27/2013	Date of Injury:	09/09/2009
Decision Date:	02/24/2014	UR Denial Date:	09/16/2013
Priority:	Standard	Application Received:	09/30/2013

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 Physical Medicine & Rehabilitation 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 42-year-old male who reported an injury on 04/01/2005. The patient is diagnosed as status post interlaminar laminotomy to the left L5-S1 in 2011, disc protrusion at C4-5 and C5-6, and cervical spine, thoracic spine, and lumbar spine myofascial pain syndrome. The patient was seen by [REDACTED] on 08/27/2013. The patient reported constant 7/10 neck pain, 8/10 low back pain, 7/10 shoulder pain, and 7/10 bilateral wrist and hand pain. Physical examination revealed restricted cervical range of motion, positive Spurling's maneuver bilaterally, weakness in the upper extremities, diminished sensation at the C5 and C6 dermatomes, and 2+ trigger point muscle strength to the cervical spine, thoracic spine, and lumbar spine. Treatment recommendations included a psychiatric followup with [REDACTED], a keyboard tray with an adjustable mouse tray, a massage chair, continuation of topical medications, and authorization for aquatic therapy for the cervical spine and lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychiatric: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398, Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405. Decision based on Non-MTUS Citation Official Disability Guidelines Mental Illness and Stress Chapter, section on Office Visits.

Decision rationale: The ACOEM Guidelines state the frequency of followup visits may be determined by the severity of symptoms, whether the patient was referred for further testing and/or psychotherapy, and whether the patient is missing work. As per the clinical documentation submitted, the patient has previously undergone psychiatric consultation and treatment. However, the current documentation does not provide details of psychiatric complaints. There is no indication of satisfactory response to previous psychiatric consultation and treatment. The medical rationale for the requested followup visit has not been established. Therefore, the request is not medically necessary and appropriate.

Keyboard with adjustable mouse tray: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 1 Prevention.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG);Knee & Leg Chapter, section on Durable Medical Equipment.

Decision rationale: The Official Disability Guidelines state durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. As per the clinical documentation submitted, the patient's physical examination on the requesting date of 08/27/2013 only addressed the cervical spine with the exception of 2+ trigger point muscle strength in the thoracic spine and lumbar spine. There was no evidence of a significant musculoskeletal or neurological abnormality with regard to the wrist and hands. The treating provider has not documented how the requested durable medical equipment would benefit the patient's current condition. The medical necessity has not been established. As such, the request is non-certified.

Massage Chair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG);Low Back, Massage

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG);Knee & Leg Chapter, section on Durable Medical Equipment.

Decision rationale: The Official Disability Guidelines state durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. As per the clinical documentation submitted, the patient's physical examination on the requesting date of 08/27/2013 only addressed the cervical spine with the exception of 2+ trigger point muscle strength in the thoracic spine and lumbar

spine. The treating provider has not documented how the requested durable medical equipment would benefit the patient's current condition. The medical necessity has not been established. As such, the request is non-certified.

8 Aquatic therapy sessions for the cervical and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

Decision rationale: The MTUS Chronic Pain Guidelines state aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. As per the clinical documentation submitted, the patient's physical examination on the requesting date of 08/27/2013 did not reveal significant musculoskeletal or neurological deficit with regard to the lumbar spine. Additionally, there is no evidence that this patient is unable to tolerate land-based physical therapy or requires reduced weightbearing. Based on the clinical information received, the request is not medically necessary and appropriate.

Flurbiprofen 20% gel 120gm: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the clinical documentation submitted, there is no evidence of failure to respond to first-line oral medication prior to initiation of a topical analgesic. Additionally, California MTUS Guidelines state the only FDA-approved topical NSAID is Voltaren gel. Based on the clinical information received, the request is not medically necessary and appropriate.

Ketoprofen 20%/Ketamine 10% gel 120gm: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the clinical documentation submitted, there is no evidence of failure to respond to first-line oral medication prior to initiation of a topical analgesic. Additionally, California MTUS Guidelines state Ketamine is not indicated for topical use. The request is not medically necessary and appropriate.

Gabapentin 10%/Cyclobenzaprine 10%/Capsaicin 0.0375% 30gm: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the clinical documentation submitted, there is no evidence of failure to respond to first-line oral medication prior to initiation of a topical analgesic. Gabapentin is not recommended as there is no peer-reviewed literature to support its use. Muscle relaxants are also not recommended as there is no evidence for the use of any muscle relaxant as a topical product. Based on the clinical information received, the request is not medically necessary and appropriate.