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| Case Number: | CM13-0046120 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 06/10/2011 |
| Decision Date: | 03/14/2014 | UR Denial Date: | 10/24/2013 |
| Priority: | Standard | Application Received: | 11/12/2013 |

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, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and 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 was a 53-year-old female who sustained an injury on 06/10/2011. The documentation submitted for review indicated the injury was due to continuous trauma relating to her bilateral wrist and hands. The patient was evaluated on 10/01/2013 which noted the patient had neck range of motion decreased with pain to paravertebral muscles. The patient had decreased range of motion to her bilateral shoulders and lumbar range of motion was decreased with low back pain. The documentation submitted for review indicated the patient had an MRI performed on 08/21/2013, which was interpreted by radiologist showing mild degenerative disc disease, most prominent at L4-5, with mild bilateral foraminal narrowing. There was a broad left L5 transverse process which articulated with the sacrum, and a noted hemangioma at L5 and a renal cyst. The patient had an EMG of the bilateral lower extremities performed on 12/26/2012 which noted an abnormal study which revealed a slight to moderate light S1 radiculopathy. The patient underwent an EMG of the bilateral upper extremities on 09/16/2013 which revealed electrophysiological evidence of bilateral median neuropathy at the wrist consistent with diagnosis of carpal tunnel syndrome, with that of a moderate degree on the right, and of a slight to moderate degree on the left. The documentation submitted for review indicated the patient participated in physical therapy program for the lumbar spine in 2011. The outcome of that physical therapy was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the lumbar spine (8 sessions):

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

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

Decision rationale: Physical therapy to the lumbar spine is non-certified. The California MTUS Guidelines recommend active therapy be based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The documentation submitted for review did not indicate the patient's pain level upon assessment. There was no supporting evidence as to the need for restoring strength, endurance, and function for the patient. The documentation did not include functional deficits and their relation to performance with ADLs. The patient was noted to have participated in a physical therapy program; however, the outcome of the program was not submitted for review. Therefore, the additional 8 sessions would exceed guideline recommendations. Given the information submitted for review the request for physical therapy to the lumbar spine is non-certified.

Voltaren gel: Upheld

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

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

Decision rationale: The request for Voltaren gel is non-certified. California MTUS Guidelines do not recommend the use for non-steroidal anti-inflammatory agents in patients with neuropathic pain. The use of Voltaren gel is indicated for relief of osteoarthritis pain and joints that lend themselves to the topical treatment such as ankle, elbow, foot, hand, knee and wrist. The documentation submitted for review did not indicate the purpose of usage for the medication. It is further noted that the request did not specify the dosage nor the amount being requested. Given the information submitted for review the request for Voltaren gel is non-certified.

Relafen 750mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

Decision rationale: The request for Relafen 750 mg is non-certified. California MTUS Guidelines recommend the use of NSAIDS for chronic low back pain as an option for short term symptomatic relief. However, the documentation submitted for review did not indicate the patient's pain level. Furthermore, the patient has been previously taking the medication and the analgesic effect was not noted. It is also noted in the documentation submitted for review the request does not specify the amount of medication being requested. Given the information submitted for review, the request for Relafen 750 mg is non-certified.