MAXIMUS Federal Services

Case Number:	CM14-0011803		
Date Assigned:	02/21/2014	Date of Injury:	09/06/2013
Decision Date:	09/29/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	01/29/2014

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 Physical Medicine and Rehabilitation and Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 47-year-old female who reported an injury 09/06/2013.due to , slipping in oil and fell on the floor, sliding forward as she fell and landing on her left side, striking her left shoulder and wrist on the door frame. The injured worker complained of her neck, lower back, left shoulder, buttocks, left wrist, and left knee pain. The injured worker had diagnoses of cervical spine strain, lumbar spine strain with sciatica, left shoulder contusion with sprain, left wrist sprain, and left knee contusion and pain. The diagnostics included an x-ray of the cervical spine dated 11/27/2013 and x-ray of the lumbar spine dated 11/27/2013 with mild facet arthrosis at the L4-5 and L5-S1 and no significant postural abnormalities. The x-ray of the left knee dated 11/27/2013 revealed no radiographic evidence of acute fracture, and early degenerative joint disease at the patellofemoral compartment was noted. The medications included ibuprofen 800 mg. The physical examination dated 11/27/2013 of the cervical and upper extremities revealed no muscle guarding and no spasms noted. There was tenderness to palpation over the cervical spine, upper trapezius, and paravertebral muscles on the left. Cervical compression was positive on the left. Flexion was 28 degrees and extension 19 degrees. The examination of the bilateral shoulders revealed no tenderness to palpation along the acromioclavicular joint. Impingement test was negative bilaterally. The flexion to the right was 140 degrees, left 96 degrees, and extension was right-sided 38 degrees and left-sided was 49 degrees. The physical examination of the lumbar spine revealed tenderness to palpation to the left lumbar paravertebral muscles at the L5-S1 spinous process and no trigger points to palpation over the thoracic or lumbar muscles, antalgic gait on the left, and no increased pain with tiptoe walking. Limited range of motion with flexion 14 degrees and extension 6 degrees. Deep tendon reflexes were 2+ bilaterally. Sensation to pinprick and light touch was within normal limits. The treatment plan included physical therapy, additional acupuncture, solar care FIR heating system with supplies, naproxen and

cyclo-keto-lidoderm cream. The Request for Authorization was not submitted with the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2X3 TO CERVICAL & LUMBAR SPINE, LEFT KNEE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request for PHYSICAL THERAPY 2X3 TO CERVICAL & LUMBAR SPINE, LEFT KNEE is not medically necessary. The California MTUS states that physical medicine with passive therapy 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. Treatment is recommended with a maximum of 9 visits to 10 visits for myalgia and myositis and 8 visits to 10 visits may be warranted for treatment of neuralgia, neuritis, and radiculitis. The documentation was not evident of any special circumstances that warrant additional therapy 6 additional sessions. As such, the request is not medically necessary.

ADDITIONAL ACUPUNCTURE 2X3 TO CERVICAL & LUMBAR SPINE, LEFT KNEE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture guidelines. (without electrical stim) Page(s): 1, 8 & 9.

Decision rationale: The request for ADDITIONAL ACUPUNCTURE 2X3 TO CERVICAL & LUMBAR SPINE, LEFT KNEE is not medically necessary. The California MTUS guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and it is recommended as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The time to produce functional improvement is 3 treatments to 6 treatments and acupuncture treatments may be extended if functional improvement is documented, including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. The injured worker received acupuncture and the documentation provided did not indicate any special circumstances to warrant 6 additional sessions of acupuncture. As such, the request is not medically necessary.

SOLAR CARE FIR HEATING SYSTEM & SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: The request for SOLAR CARE FIR HEATING SYSTEM & SUPPLIES is not medically necessary. The California MTUS states that physical medicine with passive therapy 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. There is no medical justification for a heating system pack. The request did not address the location. As such, the request is not medically necessary.

NAPROXEN CREAM AND CYCLO-KETO-LIDO: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anaprox; Cyclobenzaprine Page(s): 72, 73; 41.

Decision rationale: The request for NAPROXEN CREAM AND CYCLO-KETO-LIDO is not medically necessary. The California MTUS Guidelines indicate that Anaprox is a nonsteroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis and they recommend the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. The clinical notes did not indicate that the injured worker had a diagnosis of arthritis. A topical analgesic product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Adding cyclobenzaprine to other agents is not recommended. As such, the request is not medical necessary.