

Case Number:	CM14-0013126		
Date Assigned:	02/28/2014	Date of Injury:	05/10/2000
Decision Date:	08/15/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	02/03/2014

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 is licensed to practice in Nevada. 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 62 year-old female who was reportedly injured on May 10, 2000. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated January 13, 2014, indicates that there are ongoing complaints of neck, back and left shoulder pain. The physical examination demonstrated a decrease in left shoulder range of motion, muscle spasm in the posterior aspect of the cervical spine, positive straight leg raising and a normal strength. Diagnostic imaging studies objectified ordinary degenerative changes in the lumbar spine no acute pathology is identified. Previous treatment includes physical therapy, multiple medications and other conservative measures. A request had been made for multiple medications, additional physical therapy and a home traction unit and was not certified in the pre-authorization process on January 13, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, 12 sessions to the cervical and lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288.

Decision rationale: When considering the date of injury and that a recent partial certification for physical therapy protocol had been endorsed, there is no clinical indication to pursue additional physical therapy at this time. At most, as outlined in the American College of Occupational and Environmental Medicine guidelines, transition to home exercise protocol after one or 2 visits is all that would be supported. As such, no medical necessity has been established.

Home cervical traction unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd edition, Chapter 7 - Independent Medical Examinations and Consultations, page 127.

Decision rationale: As noted in the California Medical Treatment Utilization Schedule and American College of Occupational and Environmental Medicine guidelines, cervical traction is not recommended for acute, sub-acute or chronic pain. Furthermore, there are no high-grade scientific studies to support the use of this device or that it has any particular efficacy. Consequently there is no medical necessity established for this device.

Lidoderm patches #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56.

Decision rationale: This patch is indicated for localized peripheral pain after a failed trial of a first-line tricyclic or other type antidepressant medication to address neuropathic pain. When noting the findings identified on magnetic resonance image, there is no specific neuropathic lesion noted. Furthermore, when considering the date of injury, the lack of any report efficacy or utility with the use of this delivery model no medical necessity has been established by the treating provider.

Topical P3 compound 120gm: Upheld

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

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

Decision rationale: As noted in the California Medical Treatment Utilization Schedule, such preparations are described as "largely experimental" and that any compound product that

contains at least one drug is not recommended and the overall preparation is not recommended. The efficacy of the components of this medication has not been established. Therefore, no medical necessity is identified.

Norco 5/325mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78.

Decision rationale: This medication is a short acting opioid combined with acetaminophen. The indication is for the management of severe breakthrough pain. However, there is no noted efficacy or utility as the pain complaints have not decreased. There is no increase in functionality nor is there any identification that the use of this medication has allow for return to work. In short, there is no clinical indication to continue to use the medication that has no demonstrated positive affect. No medical necessity has been established based on the progress notes presented for review.

Prilosec 20mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67, 68.

Decision rationale: This medication is useful in the treatment of gastroesophageal reflux disease and has not been documented for this particular injured employee. There are some indication as a protectant type medication, however there is no indication of any gastrointestinal distress. Therefore, the lack of any clinical information relative to this medication, its utility or efficacy in the progress notes reviewed does not establish any medical necessity.