

Case Number:	CM14-0021233		
Date Assigned:	05/07/2014	Date of Injury:	04/23/2000
Decision Date:	07/09/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/20/2014

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, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 62 year old with an injury date on 4/23/00. Based on the 1/22/14 progress report provided the diagnoses: History of cervical spine disc protrusions with radiculopathy, exacerbation, Thoracic spine myofascial pain syndrome, History of lumbar spine disc protrusion with radiculopathy, exacerbation, L4 compression fracture, per x-rays, History of left shoulder impingement and internal derangement, Right wrist internal derangement, not related to this injury claim, and History of bilateral knee surgery, not related to this injury claim. An exam of C-spine on 1/22/14 showed range of motion decreased. The patient experiences tenderness and spasms on palpation of occipital, sub occipital, and trapezius musculature bilaterally. The compression test is positive and distraction test is negative. Range of motion: Forward flexion 35, extension 35, right lateral flexion 20, left lateral flexion 35, right rotation 65, left rotation 65. Neurological: biceps, triceps, and brachioradialis reflexes decreased at 1+ bilaterally. Left Achilles and patellar reflexes decreased at 1+. Sensation decreased to light touch and pinprick over left anterior lateral shoulder and arm, lateral forearm and hand, middle finger and medial forearm and hand." The physician is requesting one interferential unit, Mentherm gel, and physical therapy (12 sessions) including evaluation for C-spine. The utilization review determination being challenged is dated 2/10/14 and rejects request for interferential unit due to lack of documentation conservative modalities have failed, and rejects Mentherm gel due to lack of guideline support regarding menthol. The physician is the requesting provider, and he provided treatment reports from 1/22/14 to 3/12/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE(1) INTERFERENTIAL UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Medical Guidelines, Interferential Current Stimulation.

MAXIMUS guideline: Decision based on the MTUS Chronic Pain Treatment Medical Guidelines, Interferential Current Stimulation.

Decision rationale: This patient presents with neck pain that radiates to shoulders, between shoulder blades and arms, and back pain. The treater has asked one interferential unit on 1/22/14. The review of the reports does not show any evidence of an ICS unit being used in the past. Per MTUS guidelines, interferential units are recommended if medications do not work history of substance abuse or for post-operative pain control. Then, one-month rental is recommended to determine patient's response. In this request, there is no evidence that the patient has trialed a one-month use of interferential unit at home. The patient is not post-operative and there is no discussion that medications have failed. Recommendation is for denial.

MENTHODERM GEL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Chapter Topical Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications For specific recommendations, NSAIDs (non-steroidal anti-inflammatory drugs), pages 67-68 and 70-73 Page(s): 22.

Decision rationale: This patient presents with neck pain that radiates to shoulders, between shoulder blades and arms, and back pain. The treater has asked Menthoderm gel on 1/22/14 which contains salicylate, a topical NSAID. MTUS guidelines support topical NSAIDs for peripheral joint arthritis/tendinitis, but not for hip, shoulder or spinal conditions. This patient does not present with peripheral joint arthritis/tendinitis type of condition and the treater does not indicate for what condition this patient is prescribed this topical. Recommendation is for denial.

TWELVE(12) PHYSICAL THERAPY SESSION INCLUDING EVALUATION FOR THE CERVICAL SPINE: Upheld

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

MAXIMUS guideline: Decision based on the MTUS Chronic Pain Medical Treatment Guidelines, Chapter Physical Medicine Guidelines, Pages 98, 99.

Decision rationale: This patient presents with neck pain that radiates to shoulders, between shoulder blades and arms, and back pain. The treater has asked physical therapy (12 sessions) including evaluation for C-spine on 1/22/14. The 1/22/14 states patient is currently not undergoing physical therapy. Review of records show no prior history of recent physical therapy or recent surgeries. MTUS guidelines state that for myalgia and myositis, 9-10 visits are recommended over 8 weeks. For neuralgia, neuritis, and radiculitis, 8-10 visits are

recommended. In this case, the treater has asked for physical therapy (12 sessions) including evaluation for C-spine which exceeds MTUS guidelines for this type of condition. Recommendation is for denial.