

Case Number:	CM14-0035925		
Date Assigned:	06/23/2014	Date of Injury:	08/04/2010
Decision Date:	08/12/2014	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	03/24/2014

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 Orthopedic Surgery 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 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 54-year-old female who reported an injury on 08/04/2010. Prior treatments included medications, lumbar epidural steroid injections, and physical therapy. The documentation of 02/10/2014 revealed the injured worker was in the office for medication management. Medications included Flector, Flexeril, hydrocodone/acetaminophen 10/325, and Advil. The injured worker indicated she had back pain, joint pain, joint swelling, muscle weakness, and neck pain. The injured worker had maximum tenderness in the spinous, paraspinous, lumbar, and PSIS region. The injured worker had motion with pain. The greater trochanter was painful bilaterally. The injured worker had a positive straight leg raise on the right that radiated. The diagnoses included chronic pain due to trauma, failed back surgery syndrome lumbar, lumbar spondylosis without myelopathy, myalgia and myositis unspecified, and degenerative disc disease in the lumbar region. It was indicated the injured worker declined any more injections. The treatment plan included a right L3 transforaminal epidural corticosteroid injection and any IPM currently and as the injured worker had a positive L4-S1 hardware block, the injured worker was referred back to the orthopedist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Office visit x 6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 113-116.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Office Visit.

Decision rationale: The Official Disability Guidelines indicated the need for a clinical office visits with a health care provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The clinical documentation submitted for review indicated the injured worker's medications were Flector, Flexeril, hydrocodone/acetaminophen, and Advil. These medications could be followed by a primary care physician. The injured worker indicated she did not want further injections which would negate the necessity for a pain management specialist. The request as submitted was for office visits without indication of the type of visit that was being requested. Additionally 6 visits for follow up would be excessive without documentation of each visits to necessitate a subsequent visits. Given the above, the request for office visit times six is not medically necessary.

Follow up 3/10/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 113-116.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Office Visits.

Decision rationale: The Official Disability Guidelines indicated the need for a clinical office visits with a health care provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The clinical documentation submitted for review indicated the injured worker's medications were Flector, Flexeril, hydrocodone/acetaminophen, and Advil. These medications could be followed by a primary care physician. The injured worker indicated she did not want further injections which would negate the necessity for a pain management specialist. The request as submitted was for office visits without indication of the type of visit that was being requested. Given the above, the request for followup 03/10/2014 is not medically necessary.

Voltaren 1%: Upheld

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

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

Decision rationale: The California Guidelines indicate that Voltaren gel is an FDA-approved agent for the relief of osteoarthritis pain in joints that lend themselves to topical treatments such as the ankle, elbow, foot, knee, ankle, and wrist. It has not been evaluated for the treatment of the spine, hip, or shoulder. The duration of use could not be established through supplied

documentation. Additionally, there was a lack of documentation indicating the injured worker had osteoarthritis. There was a lack of documentation indicating the body part that was to be treated with the medication. The request as submitted failed to indicate the frequency and the quantity of the medication. Given the above, the request for Voltaren 1% is not medically necessary.