

Case Number:	CM14-0037610		
Date Assigned:	06/25/2014	Date of Injury:	10/23/2009
Decision Date:	08/22/2014	UR Denial Date:	03/18/2014
Priority:	Standard	Application Received:	03/28/2014

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. 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 57 year old female injured on 10/23/09 due to undisclosed mechanism of injury. Clinical note dated 04/04/14 was handwritten, largely illegible, and difficult to decipher. Prior utilization review cited clinical note dated 07/11/13 which indicated the injured worker presented complaining of right knee pain with popping, clicking, and giving way with associated difficulty with climbing, crouching, squatting, and kneeling. The injured worker also complained of low back pain radiating to bilateral buttocks. Physical examination revealed tenderness to lumbar paraspinals, positive straight leg raise, decreased range of motion of the lumbar spine, tenderness in the medial and lateral joint lines of the peripatellar region of the right knee, positive crepitus, and decreased range of motion. The injured worker tolerated injection of Synvisc during office visit and refills of Lortab and Dendracin topical lotion were provided. The initial request for ultrasound guided left shoulder subacromial injection, chiropractic care two times three to treat unspecified body parts, Voltaren 75mg Quantity 30, and Fexmid 7.5mg Quantity 60 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound guided let shoulder subacromial injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Shoulder complaints, sub-acromial injection Page(s): 63-67.

Decision rationale: As noted in the current CAMTUS, prolonged or frequent use of cortisone injections into the sub-acromial space or the shoulder joint are not recommended. There were no recent clinical records submitted for review limiting the ability to substantiate the medical necessity of the requested procedure. As such, the request for Ultrasound Guided Left Shoulder Subacromial Injection cannot be recommended as medically necessary at this time.

Chiropractic care 2x3 to treat unspecified body parts: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manuel therapy & manipulation Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Manual therapy & manipulation Page(s): 59.

Decision rationale: There were no recent clinical records submitted for review limiting the ability to substantiate the medical necessity of the requested therapy. As such, the request for Chiropractic Care to treat unspecified body parts cannot be recommended as medically necessary at this time.

Voltaren 75mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Diclofenac (Voltaren) Page(s): 43.

Decision rationale: There were no recent clinical records submitted for review limiting the ability to substantiate the medical necessity of the requested medication. As such, the request for Voltaren 75mg Quantity 30 cannot be recommended as medically necessary.

Fexmid 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Muscle relaxants (for pain) Page(s): 63.

Decision rationale: There were no recent clinical records submitted for review limiting the ability to substantiate the medical necessity of the requested medication. As such, the request for Fexmid 7.5mg Quantity 60 cannot be recommended as medically necessary at this time.