MAXIMUS Federal Services

Case Number:	CM14-0039449		
Date Assigned:	06/27/2014	Date of Injury:	10/15/2010
Decision Date:	09/30/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	04/03/2014

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 Internal Medicine and is licensed to practice in California, Florida and New York. 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 42 year old female who reported an injury on 10/15/2010 with unknown mechanism of injury. The injured worker was diagnosed with lumbar fusion at L5-S1 and artificial disk replacement at L4-5 and thoracic back pain. The injured worker was treated with medications, surgery, and physical therapy. The injured worker had unofficial x-rays on 01/22/2014. The injured worker had a lumbar fusion at L5-S1 and artificial disk replacement at L4-5 on 12/18/2012 and unknown surgery on 12/18/2013 was indicated within the medical records. The clinical note dated 12/11/2013 noted the injured worker complained of mid back radiating pain and spasms after workout and during menstruation. The injured worker had paraspinal tenderness over the thoracic region, 5/5 motor examination of bilateral upper and lower extremities. The injured worker was prescribed oxycodone 5/325mg every 4 hours as needed, voltaren cream for muscle spasms pain, and carisoprodol 350mg every 6 hours as needed for muscle spasms on the physician's report dated 01/22/2014. The treatment plan was for voltaren cream and physical therapy 2 times a week for 6 weeks. The rationale for the request was not provided in the medical records from the physician. The request for authorization was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for voltaren cream is not medically necessary. The injured worker is status post lumbar fusion at L5-S1 and artificial disk replacement at L4-5. The injured worker complains of spasms after workout and during menstruation. The California MTUS guidelines note topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed for 4-12 weeks. Topical NSAIDs are indicated for the relief of osteoarthritis pain in joints that mend themselves to topical treatment like the ankle, elbow, foot, hand, knee, and wrist. Topical NSAIDs have not been evaluated for treatment of the spine, hip or shoulder. The injured worker has been prescribed voltaren cream since at least 04/04/2013 which exceeds the recommended limit of 12 weeks. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. There is a lack of documentation indicating the injured worker has osteoarthritis and tendinitis to a joint amenable to topical treatment. Additionally, the request does not indicate the frequency, dosage, or quantity of the medication, as well as the site at which the medication is to be applied. As such, the request for voltaren cream is not medically necessary.

Physical therapy 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Carpal tunnel syndrome.

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

Decision rationale: The request for physical therapy 2 times a week for 6 weeks is not medically necessary. The injured worker is diagnosed with degenerative disc disease of the cervical spine. The California MTUS guidelines recommend 8-10 sessions of physical therapy for radiculopathy. The injured worker has documentation of physical therapy sessions extending back to 06/10/2013. The medical records lack documentation of the number of physical therapy sessions completed. There is a lack of documentation indicating the injured worker has had significant objective functional improvement with the prior sessions of physical therapy. Additionally, the request is for 12 sessions of physical therapy which exceeds the guideline recommendations. As such, the request for physical therapy 2 times a week for 6weeks is not medically necessary.