

Case Number:	CM14-0044799		
Date Assigned:	06/23/2014	Date of Injury:	05/02/2013
Decision Date:	07/22/2014	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	03/20/2014

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 and is licensed to practice in Illinois. 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 59-year-old male who reported an injury on 05/02/2013. The mechanism of injury was not provided for clinical review. The diagnoses include thoracic spine musculoligamentous sprain/strain, lumbar spine musculoligamentous sprain/strain with radiculitis, depression/anxiety, and sleep disturbance secondary to pain. Prior conservative treatments include 22 visits of physical therapy, medication, EMG/and NCS. Within the clinical note dated 01/08/2014, it was reported the injured worker complained of lower back pain which radiated to the bilateral L2, L3, and L4 dermatomes. He complained of pain in the mid upper back. He rated his mid upper back pain 3/10 in severity. His lower back pain was rated 4/10 in severity. Upon the physical examination of the thoracic spine, the provider noted tenderness to palpation over the paraspinal muscles, with palpable spasms. The examination of the lumbar spine indicated the injured worker had tenderness to palpation over the paraspinal muscles with palpable spasms. He indicated the injured worker had restricted range of motion with a positive straight leg test bilaterally. The provider requested chiropractic therapy of the thoracic spine and lumbar spine, and Methoderm. However, a rationale was not provided for clinical review. The request for authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 chiropractic visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: The request for 12 chiropractic visits between 01/08/2014 and 06/27/2014 is non-certified. The injured worker complained of lower back pain which radiated to the bilateral L2, L3, and L4 dermatomes. He rated his mid upper back pain 3/10 in severity and lower back pain 4/10 in severity. California MTUS Guidelines recommend manual therapy for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of manual therapy is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. There is a lack of documentation regarding a complete physical exam to evaluate for decreased functional ability, decreased range of motion, and decreased strength and flexibility. The request submitted of 12 visits exceeds the guideline recommendations of 6 visits over 2 weeks with evidence of objective functional improvement. Therefore, the request for 12 chiropractic visits are not medically necessary.

Menthoderm: Upheld

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

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

Decision rationale: The request for 1 prescription of Menthoderm between 01/08/2014 and 06/27/2014 is non-certified. The injured worker complained of lower back pain which radiated to the bilateral L2, L3, and L4 dermatomes. He rated his mid upper back pain 3/10 in severity and lower back pain 4/10 in severity. The California MTUS Guidelines note topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines note any compounded product that contains 1 drug or drug class that is not recommended is not recommended. Topical analgesics are indicated for osteoarthritis and tendonitis, in particular, that of the knee and elbow and other joints that are amenable to topical treatment. The guidelines recommend topical analgesics for short-term use of 4 to 12 weeks. There is lack of clinical documentation indicating the injured worker had signs and symptoms or was diagnosed with osteoarthritis. Additionally, the injured worker had been utilizing the medication for an extended period of time since at least 01/2014 which exceeds guideline recommendations of short-term use of 4 to 12 weeks. The request submitted failed to provide the frequency and quantity of the medication. In addition, the request does not specify a treatment site. The request submitted failed to provide the efficacy of the emergency department as evidenced by significant functional improvement. Therefore, the request for 1 prescription of Menthoderm is not medically necessary.

