

Case Number:	CM14-0052010		
Date Assigned:	07/07/2014	Date of Injury:	11/17/1993
Decision Date:	09/05/2014	UR Denial Date:	04/08/2014
Priority:	Standard	Application Received:	04/21/2014

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 Family Medicine 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:

This is a 64 year old patient who reported an industrial injury on 11/17/1993, almost 21 years ago, attributed to the performance of her job tasks. The patient is being treated for chronic pain. The patient complains of back pain; left thumb pain; wrist pain; shoulder pain; and neck pain. The current pain issues are attributed to the reported industrial injury 21 years ago. The objective findings on examination included tenderness to palpation and diminished range of motion to the shoulders; neck; back; hands elbows and wrists. The diagnoses included back pain; degenerative disc disease; myofascial pain; lumbar degenerative disc disease; sciatica; arthritis of the back; myofascial muscle pain; shoulder pain; wrist pain chronic; and suspected somatization disorder with many complaints not directly related to original injury. The patient was prescribed 10 sessions of physical therapy (PT) directed to the neck and back; Ativan; topical Voltaren gel; and Mag-Ox.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient physical therapy for 10 sessions for the lumbar and cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 97-98.

Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back chapter, Physical Therapy; Back chapter Physical Therapy.

Decision rationale: The request for authorization of 10 sessions of PT to the neck and back 21 years after the Date of Injury (DOI) exceeds the number of sessions of PT recommended by the CA MTUS and the time period recommended for rehabilitation. The evaluation of the patient documented no objective findings on examination to support the medical necessity of physical therapy 21 years after the cited DOI with no documented weakness or muscle atrophy as opposed to a self-directed home exercise program (HEP). There are no objective findings to support the medical necessity of 10 sessions of physical therapy for the rehabilitation of the patient over the number recommended by evidence based guidelines. The patient is documented with no signs of weakness, no significant reduction of range of motion (ROM), or muscle atrophy. There is no demonstrated medical necessity for the prescribed PT to the neck and back 21 years after the DOI. The patient is not documented to be utilizing an HEP. There is no objective evidence provided by the provider to support the medical necessity of the requested 10 sessions of PT over a self-directed home exercise program as recommended for further conditioning and strengthening. The CA MTUS recommend up to nine (9) sessions of physical therapy over 8 weeks for the hip for sprain/strains. The CA MTUS recommends ten (10) sessions of physical therapy over 8 weeks for the lumbar/cervical spine rehabilitation subsequent to lumbar/cervical strain/sprain with integration into HEP. The provider did not provide any current objective findings to support the medical necessity of additional PT beyond the number recommended by evidence based guidelines. This request is not medically necessary.

Ativan 0.5mg #40, refill 0: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-- Medications For Chronic Pain; Benzodiazepines.

Decision rationale: The prescription of Ativan for the treatment of insomnia and anxiety is inconsistent with the recommendations of the CA MTUS, ACOEM Guidelines, and the Official Disability Guidelines. The use of Ativan is associated with abuse, dependence, significant side effects related to the psychotropic properties of the medication and is not recommended by the CA MTUS. The prescription of Ativan for sleep or anxiety is not recommended due to the potential for abuse and the long half-life of the medication. Alternative medications are readily available for insomnia. The treatment of insomnia is not documented by the provider. No over the counter or other remedies were prescribed prior to prescribing a benzodiazepine. There is no documented alternative treatment with diet and exercise or evaluation of sleep hygiene. This request is not medically necessary.

MAG-Ox 400mg #30, refills 11: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-- Medical Foods/Supplements.

Decision rationale: The patient is prescribed Magnesium Oxide as a dietary supplement to replace Mg⁺⁺. There is no documented functional improvement. There is no rationale to support medical necessity. This mineral supplement is not demonstrated to have a nexus to the cited mechanism of injury or established as medically necessary with a laboratory test that demonstrates low magnesium levels. There is recommendation by evidence based guidelines for dietary supplements. There is no demonstrated medical necessity for this prescribed magnesium dietary supplement.

Voltaren 1% 500gm #1, refills 2: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 6 page 114 Official Disability Guidelines (ODG) Pain Chapter, Topical Analgesics, NSAIDs.

Decision rationale: The topical NSAID, Voltaren gel, is not medically necessary in addition to prescribed oral NSAIDs. The patient has been prescribed topical Voltaren gel in addition to oral Naproxen. The patient has received topical NSAID gels for a prolonged period of time exceeding the time period recommended by evidence based guidelines. There is no demonstrated medical necessity for both an oral NSAID and a topical NSAID. There is no provided subjective or objective evidence that the patient has failed or not responded to other conventional and recommended forms of treatment for relief of the effects of the industrial injury. Only if the subjective/objective findings are consistent with the recommendations of the CA MTUS, then topical use of topical preparations is only recommended for short-term use for specific orthopedic diagnoses. There is no documented functional improvement by the provider attributed to the topical NSAID. The use of topical NSAIDs is documented to have efficacy for only 2-4 weeks subsequent to injury and thereafter is not demonstrated to be as effective as oral NSAIDs. There is less ability to control serum levels and dosing with topical medications. The patient is not demonstrated to have any GI issue with NSAIDs. The patient was prescribed an oral and topical NSAID concurrently. The use of the topical creams/gels does not provide the appropriate therapeutic serum levels of medications due to the inaccurate dosing performed by rubbing variable amounts of creams on areas that are not precise. The volume applied and the times per day that the creams are applied are variable and do not provide consistent serum levels consistent with effective treatment. There is no medical necessity for the addition of creams to the oral medications in the same drug classes. There is no demonstrated evidence that topical medications are more effective than generic oral medications. The prolonged use of topical Voltaren gel 1%

500 g is not supported by the applicable evidence based guidelines. The continued use of topical NSAIDs for the current clinical conditions is not otherwise warranted or demonstrated to be medically necessary. The prescribed topical Voltaren gel 1% 500 g with two refills is not demonstrated to be medically necessary.