

Case Number:	CM14-0073824		
Date Assigned:	07/16/2014	Date of Injury:	03/30/2012
Decision Date:	09/22/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	05/21/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 60-year-old individual was reportedly injured on 3/30/2012. The mechanism of injury is not listed. The most recent progress note, dated 5/1/2014. There are Indications that there are ongoing complaints of neck pain, low back pain, and left shoulder postoperative pain. The physical examination demonstrated cervical spine: positive tenderness to palpation at C3-4, C4-5, and C5-6. Lumbar spine: positive tenderness to palpation L4-5, and L5-S-1. Right hand: positive Phalen's test. No recent diagnostic studies are available for review. Previous treatment includes shoulder surgery, medications, and conservative treatment. A request had been made for Epidural injections L3-4, L4-5, L5-S1 x1, bilateral wrist support, Flector patch 1.3% #60, and was not certified in the pre-authorization process on 5/9/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural injections L3-4, L4-5, L5-S1 x1 outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Effective July 18, 2009 (Final Version) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS; (Effective July 18, 2009) Page(s): 46.

Decision rationale: MTUS guidelines support epidural steroid injections when radiculopathy is documented on physical examination and corroborated by imaging and electrodiagnostic studies in individuals who have not improved with conservative care. Based on the clinical documentation provided, and considering the criteria for the use of epidural steroid injections as outlined in the MTUS; there is insufficient clinical evidence presented that the proposed procedure meets the MTUS guidelines. Specifically, there is no documentation of radiculopathy on physical exam. As such, the requested procedure is deemed not medically necessary.

Bilateral wrist support: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: MTUS/ACOEM practice guidelines support wrist splints as an option for treatment of acute, subacute or chronic carpal tunnel syndrome. Review of the available medical records, documents positive Phalen's test over the right hand/wrist. Furthermore, there was no diagnosis of carpal tunnel syndrome. As such, this request is not considered medically necessary.

Flector Patch 1.3% #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation <http://www.fda.gov/oder/foi/label/2007/021234lbl.pdf>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 111, 112.

Decision rationale: MTUS guidelines support the topical Diclofenac for the relief of osteoarthritic pain of the ankle, elbow, foot, hand, knee and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Outside of the treatment of osteoarthritis, there is no other clinical indication for the use of this topical non-steroidal anti-inflammatory. The claimant suffers from neck pain, low back and left shoulder pain. There is no indication for this medication and the request is not considered medically necessary.