

Case Number:	CM14-0148298		
Date Assigned:	09/18/2014	Date of Injury:	01/24/2014
Decision Date:	05/05/2015	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	09/11/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 40 year old female who sustained an industrial injury on 01/24/14. Initial complaints and diagnoses are not available. Treatments to date include medications and physical therapy. Diagnostic studies include a MRI. Current complaints include left shoulder and low back pain. In a progress note dated 08/06/14 the treating provider reports the plan of care as additional physical therapy, Naprosyn, Lyrica, and Lidoderm patches. The requested treatments are additional physical therapy to the left shoulder, Naprosyn, and Lidoderm patches. The 6 sessions PT were noted to decrease stiffness.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physical Therapy Qty. 6 to Left Shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, (Acute and Chronic).

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): 98-99 of 127. Decision based on

Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Medicine.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is some nonspecific decreased stiffness noted with the prior 6 PT sessions, but there is no documentation of specific objective functional improvement and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

Naprosyn EC 500mg, Qty. 60: Upheld

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

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): 67-72 of 127.

Decision rationale: Regarding the request for Naprosyn, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Naprosyn is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale) or any objective functional improvement. In the absence of such documentation, the currently requested Naprosyn is not medically necessary.

Lidoderm 5%, Qty. 60: Upheld

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

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): 112 of 127.

Decision rationale: Regarding request for Lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tricyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication of localized peripheral neuropathic pain and failure of first-line therapy. In the absence of such documentation, the currently requested Lidoderm is not medically necessary.