

Case Number:	CM15-0108785		
Date Assigned:	06/15/2015	Date of Injury:	11/06/2014
Decision Date:	07/14/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/05/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 32 year old male who sustained a work related injury November 6, 2014. While grinding metal, he bent over and developed low back pain. He was diagnosed as an acute lumbar spine sprain and treated with medication and a modified work schedule. According to a primary treating physician's initial report, dated April 16, 2015, the injured worker presented with constant lower back pain, rated 7-10/10 which radiates into the legs and down into the feet. He also complains of frequent abdominal pain associated with nausea but denies any vomiting or diarrhea. An MRI of the lumbar spine, March 20, 2015, revealed a 6mm disc protrusion at L5-S1. Physical examination revealed lumbar spine range of motion; flexion 55 degrees, extension 20 degrees, and right lateral flexion 20 degrees. He is unable to heel and toe walk bilaterally. Diagnosis is documented as L5-S1 6 mm disc herniation. Treatment plan included spine surgery consultation and urine toxicology collected. At issue, is the request for authorization for physical therapy and topical Methyl Salicylate gel (over the counter).

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy (lumbar) (visits) QTY: 12: 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, Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

Decision rationale: According to the MTUS guidelines, therapy is recommended in a fading frequency. They allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The following diagnoses have their associated recommendation for number of visits. Myalgia and myositis, unspecified 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) 24 visits over 16 weeks. According to the ACOEM guidelines: Physical and Therapeutic Interventions are recommended for 1 to 2 visits for education. This education is to be utilized for at home exercises which include stretching, relaxation, strengthening exercises, etc. There is no documentation to indicate that the sessions provided cannot be done independently by the claimant at home. Consequently, additional therapy sessions are not medically necessary. In this case, the claimant had over 24 sessions of prior PT request in the past 6 months. Response or completion of such therapy is unknown. In addition, the amount of therapy requested exceeds the guidelines recommendation. The 12 sessions of therapy requested is not medically necessary.

Kera-Tek analgesic gel: 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: Kera-Tek gel is a topical NSAID. According to the MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. In this case, the claimant does not have the above diagnoses. In addition, treatment protocol and length were not described. The request for KeraTek gel is not medically necessary.