

Case Number:	CM15-0012108		
Date Assigned:	01/29/2015	Date of Injury:	04/05/2012
Decision Date:	04/17/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/21/2015

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: Maryland

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

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 57-year-old male injured worker suffered an industrial injury on 4/5/2012. The diagnoses were cervical fusion with recurrent radiculopathy, lumbar spine strain with radiation to the right lower extremity, and chronic right cervical denervation. The diagnostic was electromyography and magnetic resonance imaging of the lumbar spine. The treatments were cervical fusion in 2012, medications, and physical therapy. The treating provider on 12/2/14 reported tenderness and muscle spasm in the trapezius with spasms. He had full active range of motion with flexion, extension and bilateral rotation. Neurovascular status was intact. The lumbar spine revealed tenderness with positive leg raise, decreased leg strength. The injured worker reported persistent neck pain at 7/10. The low back pain was 6 to 7/10 which is constant. The bilateral hands pain was 7/10, which is constant. The right knee pain is 7/10, which is constant. The document notes the patient finished all of his physical therapy for the cervical spine. There is a request for additional PT as the patient states that it helped his pain and function and to transition to a home exercise program. The Utilization Review Determination on 1/8/2015 non-certified: 1. Physical therapy 2 x week x 3 weeks for the cervical spine citing MTUS. 2. Diclofenac/Lidocaine 3%/5% cream 180 mg citing MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 x week x 3 weeks cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: Physical Therapy 2 x week x 3 weeks cervical spine is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that 10 visits are recommended for this condition with transition to an independent home exercise program. The documentation is not clear on the amount of prior cervical therapy the patient has had. Furthermore, the physical exam findings do not indicate evidence of deficits that would require 6 more supervised therapy sessions. The patient should be versed in a home exercise program by now. The request for physical therapy for the cervical spine is not medically necessary.

Diclofenac/Lidocaine Cream 3% 5% 180mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch); Topical analgesics Page(s): 56; 111-113.

Decision rationale: Diclofenac/Lidocaine Cream 3% 5% 180mg is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that topical NSAIDs are indicated in osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The guidelines indicate that topical formulations of lidocaine (whether creams, lotions or gels) are not indicated for neuropathic pain. The MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Furthermore, the MTUS guidelines state that compounded products that contains at least one drug (or drug class) that is not recommended is not recommended. The MTUS does not support topical Lidocaine in this case therefore the entire request for this cream is not medically necessary.