

Case Number:	CM15-0049564		
Date Assigned:	03/23/2015	Date of Injury:	01/14/2010
Decision Date:	05/06/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	03/16/2015

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: Utah, Arkansas

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:

This 48-year-old female sustained an industrial injury to the neck, back, shoulder and left great toe on 1/14/10. Previous treatment included physical therapy, acupuncture, magnetic resonance imaging, bilateral upper extremity electromyography and medications. In an office visit dated 3/6/15, the injured worker complained of low back pain with radiation down the right leg to the foot and bilateral neck pain. The injured worker reported that her last physical therapy was three years ago and last acupuncture was two years ago. Physical exam was remarkable for tenderness to palpation over paraspinal musculature with pain in all planes upon range of motion of the back and bilateral shoulders with protraction. The injured worker could forward flex with hands to shins and bilateral toe and heel walk without difficulty. Current diagnoses included probable post-traumatic fibromyalgia syndrome, lumbar facet syndrome versus discogenic pain, L4-5 annular tear with intermittent right L5 radiculitis and left great toe pain. The treatment plan included medications (Gabapentin, Skelaxin, Tramadol, Voltaren gel and LidoPro patches), right lower extremity electromyography, figure 8 clavicle strap, consider trigger point injections in the future and physical therapy to focus on stretching, transcutaneous electrical nerve stimulator unit trial and posture improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x 12: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17, 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Pages 98-99.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for physical therapy sessions. Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The patient has completed an unknown amount of sessions of physical therapy already. The request is for 12 additional sessions of physical therapy. According to the clinical documentation provided and current MTUS guidelines, additional Physical therapy is indicated as a medical necessity to the patient at this time, in order to learn a Home Exercise Program.

Voltaren gel 1% #1 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel, page 112. Diclofenac.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Voltaren Gel. MTUS guidelines state the following: Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. According to the clinical documentation provided and current MTUS guidelines, Voltaren Gel is not indicated as a medical necessity to the patient at this time.