

Case Number:	CM15-0055279		
Date Assigned:	03/30/2015	Date of Injury:	11/22/2013
Decision Date:	05/01/2015	UR Denial Date:	03/07/2015
Priority:	Standard	Application Received:	03/23/2015

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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational 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 injured worker is a 22-year-old male, who sustained an industrial injury on November 22, 2013. He reported neck pain, back pain, left wrist pain, bilateral knee pain, left shoulder pain and hearing loss. The injured worker was diagnosed as having cervicalgia, unspecified internal derangement of the knee, wrist sprain/strain, shoulder joint pain and thoracic spine pain. Treatment to date has included radiographic imaging, diagnostic studies, trigger point injections, physical therapy, acupuncture, medications and work restrictions. Currently, the injured worker complains of neck pain, back pain, left wrist pain, bilateral knee pain, left shoulder pain and hearing loss. The injured worker reported an industrial injury in 2013, resulting in the above noted pain. He was treated conservatively without complete resolution of the pain. Evaluation on July 11, 2014, revealed continued pain. It was noted the hearing loss had improve. Evaluation on February 17, 2015, the pain continued. The plan included continuing medications and additional physical therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications, Non-steroidal anti-inflammatory drugs, Ibuprofen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

Decision rationale: MTUS recommends the use of NSAIDS for the acute exacerbation of back pain at the lowest effective dose for the shortest amount of time due to the increased cardiovascular risk, renal, hepatic and GI side effects associated with long-term use. MTUS states "Ibuprofen (Motrin, Advil [otc], generic available): 300, 400, 600, 800 mg. Dosing: Osteoarthritis and off-label for ankylosing spondylitis: 1200 mg to 3200 mg daily. Individual patients may show no better response to 3200 mg as 2400 mg, and sufficient clinical improvement should be observed to offset potential risk of treatment with the increased dose. Higher doses are generally recommended for rheumatoid arthritis: 400-800 mg PO 3-4 times a day, use the lowest effective dose. Higher doses are usually necessary for osteoarthritis. Doses should not exceed 3200 mg/day. Mild pain to moderate pain: 400 mg PO every 4-6 hours as needed. Doses greater than 400 mg have not provided greater relief of pain." There is no documentation of sufficient clinical improvement to continue the medication. Therefore, the request is not medically necessary.

12 Physical Therapy Visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Medical records indicate a trial of physical therapy has occurred. However, there is insufficient documentation of the results and what the plan is for further sessions. Therefore, the request is not medically necessary.

