

Case Number:	CM15-0085907		
Date Assigned:	06/17/2015	Date of Injury:	05/13/2011
Decision Date:	07/15/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	05/05/2015

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: Massachusetts

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 64 year old female, who sustained an industrial injury on 05/13/2011. Initial complaints and diagnosis were not clearly documented. On provider visit dated 03/17/2015 the injured worker has reported pain in her neck, lower back, bilateral shoulders, left wrist, and right hand she complains of cervical spine pain that radiates to her right arm. Lumbar spine pain radiates to her bilateral legs. On examination of the cervical spine revealed decreased range of motion in all fields' positive cervical compression on the right with radiation into the right shoulder. Lumbar spine was noted to have a decreased range of motion, positive Kemp's bilaterally, positive straight leg raise bilaterally and shoulder revealed a bilateral decreased range of motion and positive Neer's impingement bilaterally. Wrists were note to have decreased range of motion and positive Phalen's sign. The diagnoses have included chronic cervical strain, chronic right shoulder strain, impingement, and right carpal tunnel syndrome. Treatment to date has included medication, back brace and right wrist brace. The provider requested 8 physical therapy session and Kera-Tek analgesic gel #4 oz.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Physical therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant sustained a work injury in May 2011 and continues to be treated for neck, low back, shoulder, wrist, and hand pain. When seen, and she was having radiating symptoms into the right upper and both lower extremities. Pain was rated at 5/10. There was decreased spinal range of motion with positive straight leg raising and decreased lower extremity strength. There was decreased shoulder range of motion with decreased strength and positive impingement testing. She had a positive right Phalen's test with decreased range of motion and grip strength. Tramadol and Prilosec were prescribed. The claimant is being treated for chronic pain. There is no new injury. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what would be expected to be needed to reestablish or revise a home exercise program. The request is not medically necessary.

Kera-Tek analgesic gel #4 oz: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The claimant sustained a work injury in May 2011 and continues to be treated for neck, low back, shoulder, wrist, and hand pain. When seen, and she was having radiating symptoms into the right upper and both lower extremities. Pain was rated at 5/10. There was decreased spinal range of motion with positive straight leg raising and decreased lower extremity strength. There was decreased shoulder range of motion with decreased strength and positive impingement testing. She had a positive right Phalen's test with decreased range of motion and grip strength. Tramadol and Prilosec were prescribed. The active ingredients of Keratek gel are menthol and methyl salicylate. Menthol and methyl salicylate are used as a topical analgesic in over the counter medications such as Ben-Gay or Icy Hot. Additionally, methyl salicylate metabolizes into salicylates, including salicylic acid, a non-steroidal anti-inflammatory medication. Topical non-steroidal anti-inflammatory medication can be recommended for patients with chronic pain where the target tissue is located superficially in patients who either do not tolerate, or have relative contraindications, for oral non-steroidal anti-inflammatory medications. In this case, the claimant takes Prilosec and likely has intolerance of oral NSAID medication. She has areas of localized pain amenable to topical treatment. Therefore, KeraTek can be considered as medically necessary.