

Case Number:	CM14-0120165		
Date Assigned:	08/06/2014	Date of Injury:	10/03/2013
Decision Date:	10/09/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	07/29/2014

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. The expert reviewer is Board Certified in Anesthesiology has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 42 year old male injured on 10/03/13 when he was struck in the head by a metal wall sustaining a contusion to the left side of the head. Diagnoses include cervical/thoracic/lumbar strain/sprain, cervical radiculopathy, cervical disc herniation, lumbar radiculopathy, lumbar disc herniation, right arm/wrist sprain/strain, myalgia, myositis unspecified, spasm of muscle, unspecified sleep disorder, and left knee sprain/strain internal derangement. The clinical note dated 08/01/14 indicated the injured worker presented reporting improvement in low back pain following chiropractic adjustment and acupuncture therapy. The injured worker reported occasional headaches with persistent pain at the neck and right shoulder. The injured worker reported right shoulder clicks with motions and is scheduled for a presurgical consultation on 08/19/14. The injured worker reported symptoms of anxiety, stress, depression, and sleep loss. The injured worker reported pain to the bilateral shoulders with emphasis to the right shoulder radiating to the right arm rated at 7/10. The injured worker also complained of neck pain rated at 10/10 radiating to the right upper extremity aggravated by repetitive motions of the neck. The injured worker described low back pain as dull and achy with emphasis to the left side rated at 8/10. The injured worker also complained of knee tenderness to palpation at the medial joint line bilaterally. The injured worker reports pain is reduced with rest and activity modification and has been self-medicating with pain medication prescribed by primary physician. A list of medications was not provided for review. The initial request was non-certified on 07/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% Cream 165gm Quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 112.

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Ketoprofen has not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore Ketoprofen 20% Cream 165gm Quantity: 1 cannot be recommended as medically necessary, as it does not meet established and accepted medical guidelines.

Pain Management Consultation Regarding: Epidural Steroid Injections, Cervical & Lumbar Spine Quantity: 1: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation MEDICAL TREATMENT UTILIZATION SCHEDULE (MTUS) 2009: AMERICAN COLLEGE OCCUPATIONAL AND ENVIRONMENT MEDICINE (ACOEM), OCCUPATIONAL MEDICINE PRACTICE GUIDELINES, 2ND EDITION, 2004 PAGE 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines online version, Low back Complaints.

Decision rationale: Documentation indicates the injured worker has ongoing pain and discomfort to the neck and back accompanied by abnormal diagnostic studies. As such, the request for Pain Management Consultation Regarding: Epidural Steroid Injections, Cervical & Lumbar Spine Quantity: 1 is recommended as medically necessary for further evaluation.

Knee Brace, Open Patella with Metal Stays Quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340 PARAGRAPH 2.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Knee complaints, Clinical measures, Devices, Brace.

Decision rationale: Documentation indicates the injured worker has ongoing pain and discomfort to the neck and back accompanied by abnormal diagnostic studies. As such, the

request for Pain Management Consultation Regarding: Epidural Steroid Injections, Cervical & Lumbar Spine Quantity: 1 is recommended as medically necessary for further evaluation.

Physical Therapy Treatment , for Affected Body PartsQuantity: 18: Upheld

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

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

Decision rationale: As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. The request does not specify the affected body parts to be addressed and the modalities to be utilized. As such, request for physical therapy treatment, for affected body parts, quantity: 18 is not medically necessary and appropriate.

Chiropractic Treatment, for Affected Body PartsQuantity: 18: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 59.

Decision rationale: Current guidelines indicate chiropractic frequency of 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks with a maximum duration of 8 weeks. Treatment beyond 4-6 visits should be documented with objective improvement in function. Additionally, the request did not specify the affected body parts to be addressed. As such, the request for chiropractic treatment, for affected body parts quantity: 18 is not medically necessary.

Orthopedic Surgeon Consultation for Left Knee and Right Shoulder: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MEDICAL TREATMENT UTILIZATION SCHEDULE (MTUS) 2009: AMERICAN COLLEGE OCCUPATIONAL AND ENVIRONMENT MEDICINE (ACOEM), OCCUPATIONAL MEDICINE PRACTICE GUIDELINES, 2ND EDITION, 2004 PAGE 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines online version, Low back Complaints;Follow-up visits.

Decision rationale: Documentation indicates the injured worker has ongoing pain and discomfort to the shoulder and knee accompanied by abnormal diagnostic studies. As such, the

request for Orthopedic Surgeon Consultation for Left Knee and Right Shoulder is recommended as medically necessary for further evaluation.