MAXIMUS Federal Services

Case Number:	CM14-0146750		
Date Assigned:	09/12/2014	Date of Injury:	09/19/2012
Decision Date:	10/15/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/10/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 55-year-old male with a date of injury of 09/19/2012. The listed diagnoses per [redacted] are: Cervical spine sprain/strain, bilateral shoulder tendinitis, bilateral knee pain, and Neuropathy. According to a progress report dated 06/27/2014, the patient presents with cervical and lumbar spine pain as well as bilateral shoulder, wrist, and knee pain. The patient rates his pain 5-6/10 on a pain scale. Examination revealed tenderness to the cervical and lumbar spine and paraspinal musculature. Grip strength was decreased slightly on the right more than left. The treater is requesting "acupuncture, infrared, elect, capsaicin patch 2 to 3 times a week for 4 weeks." Treater is also requesting consultation for an internal medicine evaluation and Menthoderm. Utilization review denied the request on 08/28/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture, infrared, elect, capsaicin patch 2 -3 time a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: This patient presents with neck, low back, bilateral shoulder, wrist, and knee pain. The treater is requesting acupuncture 2 to 3 times a week for 4 weeks. For acupuncture, the MTUS Guidelines recommends acupuncture for pain, suffering, and restoration of function. The recommended frequency and duration is 3 to 6 treatments to produce functional improvement 1 to 2 times per day with optimum duration of 1 to 2 months. Review of the medical files does not include treatment history. Given the patient's continued pain, a short initial course of 3 to 6 treatments may be warranted, but the treater's request for 2 to 3 sessions 4 times a week exceeds what is recommended by the MTUS Guidelines. As such, the request is not medically necessary and appropriate.

Consultation Internal Medicine Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines , 2004 Chapter 7

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004),chapter:7, page 127

Decision rationale: The ACOEM Guidelines indicate, "The occupational health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." Progress reports from 06/27/2014 and 03/06/2014 do not discuss the rationale of this request. Furthermore, the medical records provided for review do not list medications or issues that would require a referral to a specialist. As such, the request is not medically necessary and appropriate.

Menthoderm (Methyl Salicylate 15% Menthol 10%) gel 360mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals, Topical Analgesics Page(s): 105, 111.

Decision rationale: Menthoderm gel contains menthol and methyl salicylate, an NSAID. The MTUS Chronic Pain Guidelines allow for the use of topical NSAID for peripheral joint arthritis and tendinitis. Medical records provided for review do not indicate the patient has any peripheral joint arthritis or tendinitis. This medication is not indicated for neuropathic or myofascial pain. As such, the request is not medically necessary and appropriate.