

Case Number:	CM14-0191153		
Date Assigned:	11/25/2014	Date of Injury:	12/23/2013
Decision Date:	03/04/2015	UR Denial Date:	11/08/2014
Priority:	Standard	Application Received:	11/17/2014

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. 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: New York
 Certification(s)/Specialty: Emergency 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 (IW) is a 43 year old female with a slip and fall injury at work on 12/23/2013. The Injured Worker sustained injuries to her low back, upper back and knees. Diagnoses included thoracolumbar sprain with lower extremity radiculitis, bilateral sacroiliac joint sprain, bilateral knee sprain with osteoarthritis, and depression. The Injured Worker was treated with oral pain medications, chiropractic care, and physical therapy. By 04/30/2104 she had completed 6 out of the 12 approved chiropractic therapy visits. She had an additional 6 visits of physical therapy between 05/01/2014 to 05/19/2014. On 05/28/2014 she had a lumbar MRI that revealed 3.2 mm disc protrusion at L5-S1 and 3.5 mm disc protrusion at L1-L2. There was facet joint effusion consistent with a strain, arthropathy or inflammation. There was no central canal stenosis or foraminal stenosis. At PR-2 dated 7/24/2014 documents primary complaint of lumbar sacral and bilateral knee pain. Pain was rated 7 out of 10. Documentation supports the IW had completed 12 of 12 chiropractor visits. A follow-up PR-2 dated 8/5/14 documents pain radiating down leg to foot. Medications noted for the Injured Worker have included Naproxen, Cyclobenzaprine, and Norco. The documentation does not discuss the frequency and dosing of the medications that the Injured Worker is using, nor does it reveal efficacy of the treatments. Her current work status is temporary total disability. A UR decision dated November 7, 2014 certified a request for ultrasound guided Baker's cyst aspiration, modified a request for physical therapy, and non-certified a request for 1% Voltaren topical gel and Motrin 800mg prescriptions. CA MTUS chronic pain guideline and ODG guidelines were used in support of the decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy #6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 9, 98 - 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 2014, Back Pain, physical therapy

Decision rationale: According to CA MTUS, physical medicine is utilized with the overall goal of improving function. The Injured Worker has previously completed a course of physical therapy. The documentation does not demonstrate progression in her functional ability. Specifically, the Injured Worker remains TTD, there is no decrease in analgesic use noted in the documentation, and limitations of exam are unchanged. The request for physical therapy is not medically necessary.

Motrin 800 mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67 - 68, 72.

Decision rationale: According to CA MTUS chronic pain guidelines, non-steroidal anti-inflammatory agents are "recommended as an option for short term symptomatic relief" for the treatment of chronic low back pain. Further recommendations are for the lowest dose for a minimal duration of time. Specific recommendations for ibuprofen (Motrin) state "sufficient clinical improvement should be observed to offset potential risk of treatment with the increase dose." The documentation does not support improvement of symptoms with NSAIDs currently prescribed. Additionally, the request does include frequency and dosing of this medication. The request is medically not necessary.

Voltaren gel 1% #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: According to CA MTUS chronic pain guidelines, Voltaren gel, a topical non-steroid anti-inflammatory agent, is indicated for relief of osteoarthritis pain in joints. It has not

been investigated for spine, hip or shoulder. The documentation does not provide current efficacy of topical agents. It is unclear from the request on what body parts the gel would be applied, nor the frequency of application. The request is not medically necessary.