

Case Number:	CM15-0014638		
Date Assigned:	02/02/2015	Date of Injury:	07/10/2014
Decision Date:	03/27/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	01/26/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 53-year-old male who reported an injury on 07/10/2014. The mechanism of injury involved a fall. The current diagnoses include right lumbar radiculopathy, lumbar herniated nucleus pulposus, lumbar spinal stenosis, lumbar facet arthropathy, lumbar myofascial strain, and lumbago. The injured worker presented on 12/18/2014 with complaints of persistent low back and right lower extremity symptoms. It was noted that the injured worker had been previously treated with 6 sessions of acupuncture, 6 sessions of chiropractic treatment, and medication management. The current medication regimen includes prednisone 80 mg, Neurontin 600 mg, and fenoprofen 400 mg. Upon examination, there was a positive straight leg raise on the right, decreased sensation to light touch and pinprick over the right lateral/posterior thigh and calf, and 4+/5 right lower extremity weakness. There was hypertonicity in the paraspinal muscles at L3 through S1 with tenderness to palpation. Recommendations at that time included continuation of physical therapy and home exercise, as well as the current medication regimen. A transforaminal epidural injection at the right L5-S1 level was also recommended. A Request for Authorization Form was then submitted on 12/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

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

Decision rationale: The California MTUS Guidelines state any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. Therefore, the current request is not medically appropriate. There is also no strength, frequency, or quantity listed. Given the above, the request is not medically necessary.

Right Tranforaminal Epidural Steroid Injections with selective Nerve Block under fluoroscopic guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESI) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: The California MTUS Guidelines state epidural steroid injections are recommended as a treatment option for radiculopathy. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. While it is noted that the injured worker has symptoms suggestive of lumbar radiculopathy, the current request does not include a specific level or body part. As such, the request is not medically appropriate.

Physical Therapy 2 times a week for 8 weeks, lumbar spine: 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 Page(s): 98-99.

Decision rationale: The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Treatment for unspecified neuralgia, neuritis, and radiculitis includes 8 to 10 visits over 4 weeks. The current request for 16 sessions of physical therapy exceeds guideline recommendations. Therefore, the request is not medically appropriate.