

Case Number:	CM13-0007313		
Date Assigned:	12/27/2013	Date of Injury:	02/20/1990
Decision Date:	06/02/2014	UR Denial Date:	07/22/2013
Priority:	Standard	Application Received:	08/05/2013

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 Internal Medicine, and is licensed to practice in Arizona. 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 woman who sustained a work-related injury dated 2/20/1990 resulting in chronic pain. Her primary provider on 6/10/13 evaluated her with a diagnosis of cervical radiculopathy, lumbar radiculopathy, bilateral shoulder and knee arthralgia, multilevel cervical bilateral neural foraminal narrowing, moderate, canal stenosis at C3-4 and C4-5 and L4-5 and L5-S1. During the counter she complains of 6/10 neck and back pain with numbness in bilateral feet and radiation of pain down left arm to the hand. She is working full duty with increased pain during work. Physical exam shows decreased range of motion of the cervical, thoracic and lumbar spine. Decreased sensation in several dermatomes and equal motor strength bilateral that is limited by pain. The injured worker notes that she has ongoing follow-up with a primary provider for her headaches and that her medications cause diarrhea and GI upset. Previous treatment includes 18 visits of acupuncture and 3 visits of chiropractic care. The chiropractic care is noted to help "somewhat" for the pain. The primary provider requested treatment including medial branch block of bilateral L3-4, Terocin topical cream, general practitioner consult for GI upset and chiropractic treatment of the neck and back-8visits. These services were denied as not medically necessary on 7/22/13 during utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TEROCIN PAIN RELIEF LOTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 110-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section 9792.20-9792.20.26 Page(s): 111-113.

Decision rationale: Terocin cream contains capsaicin, Lidocaine, menthol and methyl salicylate. Topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or and AED (Gabapentin or Lyrica). Not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. Regarding the use of Terocin cream for the use of chronic pain, Lidocaine and capsaicin are considered not medically necessary due to the lack of documentation that the patient has tried and failed first line therapy. Furthermore the patient is not being treated for post-herpetic neuralgia, which is the only approved use for topical Lidocaine. According to the MTUS, if a single ingredient in a compounded topical analgesic is medically unnecessary then the entire compound is unnecessary.

MEDIAL BRANCH BLOCK, BILATERALLY AT L3-L4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation as well as ODG, Low Back Chapter, facet joint diagnostic blocks (injections) section.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315.

Decision rationale: The injured worker is being treated for degeneration of intervertebral disc, cervical spinal stenosis, and lumbar and cervical intervertebral disc disease without myelopathy. The primary provider is requesting a medial branch block of bilateral L3-L4. According to the MTUS invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. The use of a medial branch block at L3-L4 level is not medically necessary.

INTERNAL MEDICINE/GENERAL PRACTITIONER CONSULTATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM for Independent Medical Examinations and Consultations regarding Referrals, Chapter 7, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Uptodate.com Approach to the patient with nausea.

Decision rationale: The injured worker is being treated for degeneration of intervertebral disc, cervical spinal stenosis, and lumbar and cervical intervertebral disc disease without myelopathy. It was noted that the injured worker has diarrhea and GI upset with medications without a thorough history or physical exam being done to assess for other causes. A medical consultation for GI upset is not medically necessary due to failure of the documentation to support any significant symptoms or an abnormal exam.

ADDITIONAL CHIROPRACTIC TREATMENT FOR THE NECK AND BACK, EIGHT (8) VISITS TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315.

Decision rationale: The injured worker is being treated for degeneration of intervertebral disc, cervical spinal stenosis, and lumbar and cervical intervertebral disc disease without myelopathy with a date of injury of 2/20/1990. According to the MTUS manipulation appears safe and effective in the first few weeks of back pain without radiculopathy. For patients with symptoms lasting longer than one month, manipulation is probably safe but efficacy has not been proved. In this case the injured worker has had chronic pain lasting longer than one month. The benefit that the first three chiropractic treatments gave are described as "somewhat helpful to decrease pain". In this case the additional chiropractic treatments are not medically necessary as the documentation does not state the initial treatments showed significant improvement in pain and the pain has lasted longer than one month.