

Case Number:	CM13-0028374		
Date Assigned:	11/27/2013	Date of Injury:	10/13/2011
Decision Date:	04/25/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, 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 Physician 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 35-year-old female who reported injury on 10/13/2011. The mechanism of injury was noted to be the patient was pulling a metal table on wheels weighing about 60 pounds. The patient's prior treatments included acupuncture, physical therapy, chiropractic care, and ESWT. The patient's medication history included Prilosec, Ketoprofen, and NSAIDs as of 2011. The documentation of 07/31/2013 revealed that the patient had 3 epidural steroid injections. The patient had complains of low back pain. The patient had radiation of the pain down the posterior aspect of the lower extremities to the level of her feet bilaterally. The patient had weakness of both legs and numbness and tingling of the bilateral lower extremities. The physical examination of the lumbar spine indicated that the patient had pain upon palpation over the supraspinous ligament from L4 through the sacrum. There was muscle guarding with range of motion, however no paralumbar muscle spasm was noted. The patient had decreased range of motion and motor strength was normal at 5/5. The patient's sensation was within normal limits in all lower extremity dermatomes. The diagnoses indicate lumbosacral myofasciitis, L4-S1 disc bulges causing bilateral neural foraminal narrowing per MRI, mechanical discogenic low back pain, and rule out lumbar radiculopathy. The recommendations/treatment plan included chiropractic manipulation, Ketoprofen, Prilosec, gabapentin, and Theraflex, as well as BioTherm lotion.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENT TO THE LUMBAR SPINE, 2x/WK x 4 WKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Manual Therapy, Page(s): 58-59.

Decision rationale: The MTUS Guidelines recommend manual therapy for chronic pain if it is caused by a musculoskeletal condition. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. The clinical documentation submitted for review failed to indicate the employee's prior success with chiropractic care. As it was noted the employee had chiropractic care in 2011 and 2012. Additionally, there was lack of documentation indicating this was a flare-up of a condition versus a chronic pain syndrome. The request for 8 visits would exceed guidelines as the guidelines indicate that a therapeutic trial of 6 sessions is appropriate dependent upon re-evaluation. There is lack of documentation of the functional efficacy of the prior treatment. Given the above, the request for chiropractic treatment to the lumbar spine 2 times a week times 4 weeks is not medically necessary.

PRILOSEC CAP 20 MG, 1 P.O. QD, 60 DAY SUPPLY, 60 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section NSAIDs Page(s): 69.

Decision rationale: The MTUS Guidelines recommend PPIs (proton pump inhibitors) for the treatment of dyspepsia secondary to NSAID therapy. Clinical documentation submitted for review indicated the employee had been taking medication since 2011. There was lack of documentation of the efficacy of the requested medication. There was a lack of documentation indicating the necessity for a 60 day supply without re-evaluation. Given the above, the request for Prilosec Cap 20 mg 1 by mouth, daily, 60 day supply, 60 count is not medically necessary.

KETOPROFEN CAP 75 MG, 1 P.O. TID, 30 DAY SUPPLY, 90 COUNT: Upheld

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

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

Decision rationale: treatment for low back pain. There should be documentation of objective functional improvement and an objective decrease in the VAS (visual analog scale) score. Clinical documentation submitted for review indicated the employee was prescribed 2 forms of NSAIDs. There was lack of documentation indicating the necessity for 2 forms. Additionally, the employee was noted to be taking NSAIDs since 2011. There is lack of documentation indicating

the employee had objective functional improvement and an objective decrease in the VAS score. Given the above, the request for Ketoprofen Cap 75 mg 1 by mouth, 3 times a day, 30 day supply, 90 count is not medically necessary.

DYOTIN 250 MG, 2 P.O. QD, 60 DAY SUPPLY, 120 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Anti-epileptic Drugs, Page(s): 16.

Decision rationale: The MTUS Guidelines recommend anti-epileptic drugs for the treatment of neuropathic pain. Clinical documentation submitted for review indicated that the employee had signs and symptoms of neuropathic pain. The duration of this medication could not be established through documentation. The request as submitted was for a 60-day supply. There is lack of documentation indicating a necessity for 60-day supply without re-evaluation. Given the above, the request for Dyotin 250 mg 2 by mouth, daily, 60 day supply, 120 count is not medically necessary.

THERAFLEX ULTRA CREAM 180 GM, 3-4x PER DAY, 45 DAY SUPPLY, 180 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Topical Analgesics, Flurbiprofen, Cyclobenzaprine Page(s): 111,72,41.

Decision rationale: The MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed....Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Flurbiprofen is classified as a non-steroidal anti-inflammatory agent. This agent is not currently FDA approved for a topical application. FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine - National Institutes of Health (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration...The MTUS Guidelines do not recommend the topical use of Cyclobenzaprine as a topical muscle relaxant as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine to other agents is not recommended. The clinical documentation indicated the employee had been utilizing topical creams for more than one year. Clinical documentation submitted for review failed to indicate the employee had trials of antidepressants and anticonvulsants that had failed. Additionally, as flurbiprofen is not recommended for topical

application, the request would not be supported. There is lack of documentation indicating a necessity for both an oral and topical form of NSAID. Given the above, the request for Theraflex Ultra Cream 180 gm, 3 to 4 times per day, 45 day supply, 180 count is not medically necessary.

BIO-THERM LOTION 120 GM, 3-4 TIMES PER DAY, 45 DAY SUPPLY, 4 OZ.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Topical Salicylates, Page(s): 105.

Decision rationale: The MTUS Guidelines recommend topical salicylates for the treatment of chronic pain. There is lack of documentation indicating the ingredients in the BioTherm lotion. Additionally, the employee was noted to be treated with topical creams for greater than 1 year. There is lack of documentation of the efficacy of the topical treatments. Given the above, the request for BioTherm lotion 120 gm, 3 to 4 times per day, 45 day supply, 4 ounces, is not medically necessary.