

Case Number:	CM13-0042149		
Date Assigned:	12/27/2013	Date of Injury:	05/26/2009
Decision Date:	04/21/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	10/16/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, 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:

This is a patient with a date of injury of May 26, 2009. A utilization review determination dated September 11, 2013, recommends non-certification of chiropractic, Flector patch, Nucynta, Robaxin, and purchase of a muscle stimulator. An August 22, 2013, medical report identifies low back pain and right leg numbness, neck pain with radiation to the left scapular area, upper and mid-back pain with occasional burning sensation, and bilateral shoulder and scapular pain. On exam, there is lumbar spasm with limited ROM (range of motion) and positive SLR (straight leg raise) on the right at 70 degrees. Cervical tenderness with limited ROM and positive left Spurling's sign producing left scapular pain is noted. There is slightly limited shoulder abduction and flexion. Mood and affect are mildly depressed.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENT 1 TIMES A WEEK FOR 12 WEEKS WITH [REDACTED]
[REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: Regarding the request for chiropractic treatment with [REDACTED] once per week for twelve weeks, the Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to six visits over two weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to eighteen visits over six to eight weeks may be supported. Within the documentation available for review, it is noted that the patient has completed prior chiropractic sessions, but there is no documentation to support functional improvement or identifying the need for ongoing supervised treatment rather than independent home exercise to address any remaining functional deficits. The request for chiropractic treatment with [REDACTED], once per week for twelve weeks is not medically necessary or appropriate.

FLECTOR PATCH 1.3%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-1112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-1112.

Decision rationale: Regarding the request for Flector patch, the Chronic Pain Medical Treatment Guidelines cites that topical NSAIDs (non-steroidal anti-inflammatory drugs) are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." That has not been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. The request for a Flector Patch 1.3% is not medically necessary or appropriate.

NUCYNTA 50 MG, #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79 - 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79.

Decision rationale: Regarding the request for Nucynta, the Chronic Pain Medical Treatment Guidelines state that, due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. Opioids should not be abruptly discontinued; however,

unfortunately, there is no provision for modification of the current request. The request for Nucynta 50 mg, 100 count, is not medically necessary or appropriate.

ROBAXIN 500 MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: Regarding the request for Robaxin, the Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. The request for Robaxin 500 mg, 60 count, is not medically necessary or appropriate.

PURCHASE OF MUSCLE STIMULATOR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114 - 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

Decision rationale: Regarding the request for purchase of a muscle stimulator, the Chronic Pain Medical Treatment Guidelines notes that neuromuscular electrical stimulation devices are not recommended, as they are used primarily as part of a rehabilitation program following stroke and there is no evidence to support their use in chronic pain. There are no intervention trials suggesting benefit from NMES (neuromuscular electrical stimulator) for chronic pain. There is some support for a trial of some forms of electrical stimulation such as TENS (transcutaneous electrical nerve stimulator), but unfortunately, there is no provision for modification of the current request. The request for the purchase of a muscle stimulator is not medically necessary or appropriate.