

Case Number:	CM14-0005954		
Date Assigned:	02/05/2014	Date of Injury:	04/26/2011
Decision Date:	06/20/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/13/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in Texas. 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 patient is a 53 year old female injured on 4/26/11 when involved in a motor vehicle collision. A clinical note dated 12/27/13 indicated that the patient complained of low back pain with intermittent radiation to the right lower extremity and right hip. Physical examination of the lumbar spine revealed tenderness to palpation in the midline L3-5, and tenderness in the bilateral paraspinal muscles with right side greater than left. Examination revealed negative straight leg raise bilaterally, 5/5 strength in all muscle groups bilaterally, and tenderness in the right side greater trochanter with slight increased pain while performing internal and external movement. The patient was to continue with acupuncture and begin six sessions of physical therapy. Medications included TG Hot cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY, LUMBAR SPINE QUANTITY: 12.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN TREATMENT GUIDELINES, CHAPTER PHYSICAL MEDICINE, 98-99

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, 9792.20, PHYSICAL MEDICINE, PAGE 98

Decision rationale: As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend 10 visits of physical therapy over 8 weeks for the treatment of lumbar strain/sprain. The treatment plan should allow for the fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus the addition of active self-directed home physical therapy. There is no documentation of exceptional factors that would support the need for therapy that exceeds guidelines either in duration of treatment or number of visits. As such, the request is not medically necessary.

TGHOT: TRAMADOL8%/GABAPENTIN10%/MENTHOL 2%/CAMPHOR 2% 120GM QUANTITY: 2.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CHAPTER TOPICAL ANALGESICS, 111-113

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, 9792.20, TOPICAL ANALGESICS, PAGE 111

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Furthermore, the MTUS requires that all components of a compounded topical medication be approved for transdermal use. This compound contains Tramadol and gabapentin, both of which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. As such, the request is not medically necessary.

MAGNETIC RESONANCE IMAGING (MRI) LUMBAR SPINE QUANTITY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE, CHAPTER 12, LOW BACK COMPLAINTS, 303

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12)

Decision rationale: MRI is not recommended in cases of uncomplicated low back pain with radiculopathy until after at least one month conservative therapy, sooner if severe or progressive neurologic deficits are noted. Repeat MRI is not routinely recommended, and should be reserved

for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). The clinical documentation fails to establish compelling objective data to substantiate the presence of radiculopathy or neurologic deficit. Additionally, there is no indication that the patient has undergone at least one month of conservative treatment. As such, the request is not medically necessary.