

<b>Case Number:</b>	CM14-0100430		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	07/14/2008
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 40-year-old male with a reported date of injury on 07/14/2008. The mechanism of injury was not provided within the documentation available for review. The injured worker's diagnosis included displacement of lumbar intervertebral disc without myelopathy. The injured worker underwent an L5-S1 discectomy in 06/2010. The injured worker's medication regimen was noted to include tramadol. The information provided for review did not contain clinical documentation. The Request for Authorization for MRI of the lumbar spine with IV gadolinium; transdermal cream Ibuprofen 10%, 60 gm, apply 2 times per day; cyclobenzaprine 2% cream 60 gm, apply at bedtime; and chiropractic treatment was submitted on 06/30/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of Lumbar Spine with IV Gadolinium:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The California MTUS Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurological examination is less clear, however, further physiological evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false positive findings, such as disc bulges, that are not the source of painful symptoms and do not warrant surgery. If physiological evidence indicates tissue insult or nerve impairment, the practitioner can discuss with the consultant the selection of an imaging test to define a potential cause. The information provided for review does not contain clinical documentation. There is a lack of documentation related to the injured worker's functional or neurological deficits. As such, the request for MRI of Lumbar Spine with IV Gadolinium is not medically necessary.

**Transdermal cream Ibuprofen 10 %, 60 Gms., apply BID (2 times per day):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The California MTUS Guidelines recommend topical analgesics as an option. Although largely experimental in use with few randomized controlled trials to determine effectiveness or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In addition, the Guidelines state that nonsteroidal anti-inflammatory agents in clinical trials for this treatment modality have been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but with a diminishing effect over another 2-week period. The information provided for review does not contain clinical notes. There is a lack of documentation related to the injured worker's functional and neurological deficits. In addition, there is a lack of documentation related to the injured worker suffering from neuropathic pain and/or the trial of antidepressants and anticonvulsants having subsequently failed. As such, the request for Transdermal cream Ibuprofen 10 %, 60 gms., apply BID (2 times per day) is not medically necessary.

**Cyclobenzaprine 2% cream 60 gm., apply at bedtime (QHS):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111 & 113.

**Decision rationale:** The California MTUS Guidelines recommend topical analgesics as an option. Although largely experimental in use with few randomized controlled trials to determine effectiveness or safety. Topical analgesics are primarily recommended for neuropathic pain

when trials of antidepressants and anticonvulsants have failed. In addition, the Guidelines state that there is no evidence for use of any other muscle relaxant as a topical product. The information provided for review lacks clinical documentation. There is a lack of documentation related to the injured worker's functional or neurological deficits. In addition, the Guidelines do not recommend muscle relaxants as a topical agent. As such, the request for Cyclobenzaprine 2% cream 60 gm., apply at bedtime (QHS) is not medically necessary.

**Chiropractic Treatment 2 x week x 4 weeks to lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58.

**Decision rationale:** The California MTUS Guidelines recommend manual therapy and manipulation for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manual medicine for the low back is recommended as an option. Therapeutic care is recommended at a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. The information provided for review contains no clinical documentation. There is a lack of documentation related to the injured worker's functional and neurological deficits. In addition, the request for 8 chiropractic treatments exceeds the recommended Guidelines. As such, the request for Chiropractic Treatment 2 x week x 4 weeks to lumbar spine is not medically necessary.