

Case Number:	CM14-0123951		
Date Assigned:	08/08/2014	Date of Injury:	07/01/2013
Decision Date:	09/11/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	08/05/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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:

The injured worker is a 50 year old female injured on 07/01/13 as a result of repetitive motion. Current diagnoses include cervical radiculitis and 3mm bulging disc at C5-6 and C6-7. Clinical note dated 06/17/14 indicates the injured worker presented complaining of neck pain. The injured worker reported not taking pain medications because she didn't like the way it made her feel. Physical examination revealed decreased range of motion and muscle strength 5/5 in all muscle groups. Treatment plan included physical therapy, topical cream, IF unit, acupuncture, and chiropractic treatment. Clinical note dated 07/15/14 indicated the injured worker presented complaining of neck and arm pain. Documentation indicated the injured worker was attempting to avoid surgical intervention in the form of anterior decompression and fusion at C5-6 and C6-7 through conservative treatment measures. The injured worker recommended topical creams due to lack of efficacy. Physical examination revealed decreased range of motion of the cervical spine and 5/5 muscle strength. The initial request for additional acupuncture 1 x 8 for cervical spine and ketoprofen/gabapentin cream as prescribed on 07/14/14 was initially non-certified on 07/18/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional acupuncture 1x8 for cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: As noted in the Acupuncture Medical Treatment Guidelines, the frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed 1 to 3 times per week with an optimum duration over 1 to 2 months. Guidelines indicate that the expected time to produce functional improvement is 3 to 6 treatments. Acupuncture treatments may be extended if functional improvement is documented. There is no documentation of functional improvement provided for review. As such, the request for Additional acupuncture 1x8 for cervical spine cannot be recommended as medically necessary.

Ketoprofen/Gabapentin Cream as prescribed on 7/14/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (updated 07/10/14), Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 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. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Both components of this compound have yet to be 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. Therefore Ketoprofen/Gabapentin Cream as prescribed on 7/14/14 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.