

Case Number:	CM14-0021296		
Date Assigned:	05/07/2014	Date of Injury:	03/19/2012
Decision Date:	07/09/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	02/20/2014

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 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 58 year old female who reported an injury on 03/20/2012. Per the clinical note dated 04/23/2014, the injured worker indicated low back pain with intermittent numbness and tingling in the left leg. It was also noted that the injured worker underwent an epidural steroid injection on 08/23/2013 for left leg radiculopathy. It is further revealed that the injured worker was concurrently attending physiotherapy 3 times a week for the left shoulder. The physical exam of the lumbar spine revealed decreased range of motion and flexion 30 degrees, extension 0 degrees, left lateral flexion 10 degrees, right lateral flexion 15 degrees, left rotation 25 degrees, and right rotation 15 degrees. The diagnoses included sacroiliac sprain/strain, lumbar disc bulge with radiculitis, cervical disc bulge with radiculitis, internal derangement of the knees, bilateral shoulder tendonitis, and bilateral rotator cuff syndrome. The request for authorization was dated 04/23/2014 for pain mitigation.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE TO THE LUMBAR SPINE 3 X 4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The MTUS Acupuncture Guidelines recommend acupuncture is to be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The MTUS Guidelines further state that the frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed when functional improvement is objectively shown within 3 to 6 treatments. Furthermore, the frequency is outlined as 1 to 3 times per week over an optimum duration of 2 to 3 months. The request indicates a utilization of acupuncture 3 times a week for 4 weeks for a total of visits which exceeds the recommendations of the MTUS Acupuncture Guidelines. Lastly, the request does not indicate whether the acupuncture is to replace physical therapy or to be used in conjunction with physical therapy and there was no documentation within the last clinical note of a medication history. Given the request exceeds the guideline recommendations for the maximum frequency of visits and the guideline recommendations to show functional improvement after the specified time to produce effect, the request is not medically necessary and appropriate.

REFERRAL TO PAIN MANAGEMENT TO EVALUATE LESI #2 AND #3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Office visits.

Decision rationale: The Official Disability Guidelines (ODG) state that office visits are recommended as determined to be medically necessary. The ODG further states that clinical office visits with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or some medicines such as certain antibiotics require close monitoring. It was not indicated what medications the injured worker was taking within the submitted medical records. In addition, the patient's clinical stability had not changed with reports of any increased pain or significant functional changes. Without a clear rationale as to why the current treating physician is unable to facilitate managing the injured worker's pain and why the current physician is unable to gain authorization for additional steroid injections, it is not supported by the guidelines at this time. As such, the request is not medically necessary and appropriate.

FLEXERIL 7.5MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: The MTUS Chronic Pain Guidelines recommend Cyclobenzaprine for a short course of therapy. Limited, mixed evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants. It is unknown within the documentation if this is a newly prescribed medication or if it had been prescribed in the past due to a lack of documentation of the pharmaceutical interventions utilized during the injured worker's time injured. In addition, within the physical exam, the injured worker neither complained of spasms, nor did physical exam document muscle spasms and the MTUS Chronic Pain Guidelines do not support the medication requested. As such, the request is not medically necessary and appropriate.

TOPICAL TRANSDERMAL CREAMS: FLURIBIPROFEN 20% 30 GRAMS, TRAMADOL 20% 30 GRAMS AND CYCLOBENZAPRINE/GABAPENTIN 10 30GRAMS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The MTUS Chronic Pain Guidelines recommend topical analgesics primary for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines further state that for topical analgesics, any compounded product that contains at least 1 drug that is not recommended the entire compounded product is as such not recommended. The guidelines state for topical NSAIDs, the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and shorter duration with indications that topical NSAIDs are indicated for chronic musculoskeletal pain, but there are no long-term studies of the effectiveness or safety. Additionally, the MTUS Chronic Pain Guidelines state for neuropathic pain, topical NSAIDs are not recommended as there is no evidence to support their use. As for the compounded products utilization of Gabapentin, the Guidelines state that it is not recommended and there is no peer reviewed literature to support its use. Given the compounded product's numerous active ingredients that are not approved by the guidelines and lack of documentation to show that the patient has been intolerant of oral medications, the request is not medically necessary and appropriate.