

Case Number:	CM14-0038851		
Date Assigned:	06/27/2014	Date of Injury:	07/25/2013
Decision Date:	08/15/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/02/2014

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 and Nevada. 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 49 year old male who sustained an injury on 07/25/13. No specific mechanism of injury was noted. The injured worker has been followed for complaints of chronic low back pain radiating to the lower extremities. Prior conservative treatment has included the use of physical therapy as well as chiropractic manipulation and multiple injections. The injured worker has had a prior surgery for these complaints and has been followed by pain management. With medications, the injured worker's pain was well-controlled at 2-3/10 on the visual analog scale. Without medications, the injured worker's pain was felt to be uncontrolled. Prior medication use did include Norco 10/325mg every 4-6 hours for pain as well as Gralise 600mg for neuropathic pain. Prior urine drug screen testing was consistent with these medications. The injured worker was seen on 02/03/14 with continuing complaints of chronic low back pain. The injured worker denied any side effects with the medications. Other noted medications included a Medrol dose pack. Physical examination noted loss of lumbar range of motion with tenderness to palpation present. There was pain reported radiating through the right lower extremity and straight leg raise testing was positive bilaterally. The injured worker did have an antalgic gait and utilized a single point cane for ambulation. There was decreased sensation to the right in an L5-S1 distribution. The recommendation was for continuation of Norco and Gralise. The injured worker did have a recent epidural steroid injection completed on 02/05/14. The requested chiropractic treatment for 6 sessions, computerized range of motion and muscle testing, electrodiagnostic (EMG and NCV) studies, as well as topical compounded medication to include Flurbiprofen, Tramadol, Menthol, Camphor, and Capsaicin 240 grams was denied by utilization review on an undetermined date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment, Chiropractic supervised physiotherapy 6 treatments: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation, Physical Medicine Page(s): 58-60, 98-99.

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

Decision rationale: In regards to the request for chiropractic treatment x 6 sessions, this reviewer would not have recommended this request as medically necessary. The injured worker has a date of injury now over 1 year old. The clinical documentation submitted for review did not provide any recent rationale for the requested chiropractic therapy. It is noted that the injured worker has had prior chiropractic therapy; however, it is unclear what benefits were obtained with prior chiropractic manipulation. No updated evaluation was available for review with specific goals to be obtained with the use of chiropractic therapy that would support this request as medically necessary.

Computerized tracker range of motion and muscle testing: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, range of motion.

Decision rationale: In regards to the request for computerized range of motion and muscle testing, this reviewer would not have recommended this request as medically necessary. From the literature, there is no clear indication that computerized measurements and muscle testing is any more accurate or provides more clinical information to help guide treatment than standard assessments utilizing inclinometer tools and the attending physician's judgment. Therefore, this reviewer would not have recommended this request as medically necessary.

EMG bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178,303.

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

Decision rationale: In regards to the request for electrodiagnostic (EMG) studies of the bilateral lower extremities, this reviewer would not recommend this diagnostic test as medically

necessary. From the clinical documentation provided for review, there is sufficient evidence to establish a diagnosis of chronic lumbar radiculopathy. The injured worker's physical examination findings have been fairly stable with no new findings readily apparent. In this case, it is unclear how further electrodiagnostic testing to include EMG would provide further clinical information that would help guide the injured worker's course of treatment. Therefore, this reviewer would not recommend the request as medically necessary.

**Capsaicin 0.025%, Flurbiprofen 15%, Tramadol 15%, Menthol 2%, Camphor 2%;
240gm: Upheld**

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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

Decision rationale: In regards to the use of topical compounded medication that contains Capsaicin, Flurbiprofen, Tramadol, Menthol, and Camphor 240gm, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The Chronic Pain Medical Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Flurbiprofen and Tramadol which are not approved for transdermal use. The clinical documentation provided did not discuss that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound cannot be supported as medically necessary.