

Case Number:	CM14-0043070		
Date Assigned:	06/30/2014	Date of Injury:	02/18/1990
Decision Date:	07/30/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	04/10/2014

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 Management 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:

According to the records made available for review, this is a 58-year-old female with a 2/18/90 date of injury. At the time (2/28/14) of the request for authorization for chiropractor three times a week for three weeks (3x3) to cervical spine, Tylenol with Codeine #3 30/300 #180 with One (1) refill, and DF (Diclofenac/Flurbiprofen Cream Diclof 5%/Flurbi 6% with 11 refills. There is documentation of subjective complaints of (neck pain and right arm pain) and objective findings of (midline cervical spine tenderness, range of motion is decreased); current diagnoses include (muscle spasm, cervical disc displacement with myelopathy, hypesthesia, and osteoarthritis other specified), and treatment to date includes medication management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractor three times a week for three weeks (3x3) to cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 60-61.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58.

Decision rationale: MTUS reference to ACOEM identifies documentation of occupationally related neck pain or cervicogenic headache, objective functional deficits, and functional goals, as criteria necessary to support the medical necessity of chiropractic treatment. In addition, MTUS Chronic Pain Medical Treatment Guidelines supports a trial of 6 visits, with evidence of objective functional improvement, total of up to 18 visits. Within the medical information available for review, there is documentation of diagnoses of muscle spasm, cervical disc displacement with myelopathy, hypesthesia, and osteoarthritis other specified. In addition, there is documentation of occupationally related neck pain, objective functional deficits, and functional goals. However, the requested chiropractic Treatment three times a week for three weeks (3x3) to cervical spine exceeds guidelines (for an initial trial). Therefore, based on guidelines and a review of the evidence, the request for chiropractic Treatment three times a week for three weeks (3x3) to cervical spine is not medically necessary.

Tylenol with Codeine #3 30/300 #180 with One (1) refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Outcome Measures Page(s): 82-88.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar post-laminectomy syndrome and chronic pain syndrome. In addition, there is documentation of treatment with Tylenol with Codeine for at least 8 months. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with use of Tylenol with Codeine. Therefore, based on guidelines and a review of the evidence, the request for Tylenol with Codeine #3 30/300 #180 with One (1) refill is not medically necessary.

DF (DicloIfenac/Flurbiprofen Cream Diclof 5%/Flurbi 6% with 11 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 117-119. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of topical NSAIDs. ODG identifies the need for documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Within the medical information available for review, there is documentation of diagnoses of muscle spasm, cervical disc displacement with myelopathy, hyperesthesia, and osteoarthrosis other specified. However, despite documentation of a diagnosis of osteoarthrosis, there is no (clear) documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist), short-term use (4-12 weeks), and failure of an oral NSAID or contraindications to oral NSAIDs. Therefore, based on guidelines and a review of the evidence, the request for DF (Diclofenac/Flurbiprofen Cream Diclof 5%/Flurbi 6% with 11 refills is not medically necessary.