

Case Number:	CM14-0046732		
Date Assigned:	07/02/2014	Date of Injury:	03/07/2012
Decision Date:	08/29/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/14/2014

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 Texas and Ohio. 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 51 year old female who reported an injury on 03/07/2012 due to repetitive trauma while performing normal job duties. The injured worker reportedly sustained an injury to her low back. The injured worker's treatment history included physical therapy, a TENS unit, and multiple medications. The injured worker was evaluated on 06/02/2014. It was documented that the injured worker had continued pain complaints. It was noted that the injured worker had previously participated in 12 visits of physical therapy and 11 visits of chiropractic care. Physical findings included decreased motor strength of the bilateral upper extremities, tenderness to palpation of the cervical spine, tenderness to palpation of the lumbar spine, and a positive straight leg raise test. A request was made for chiropractic care and refill of medications. However, no justification for the request was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment two (2) times a week for three (3) weeks.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

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

Decision rationale: The requested chiropractic treatment 2 times a week for 3 weeks is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing chiropractic treatment be based on documented functional benefit and symptom response to previous treatments. The clinical documentation submitted for review does indicate that the injured worker previously participated in 11 visits of chiropractic care. However, the clinical documentation fails to provide any evidence of significant functional benefit resulting from prior treatment. California Medical Treatment Utilization Schedule does not recommend maintenance manual manipulation or therapy. As such, the requested chiropractic treatment 2 times a week for 3 weeks is not medically necessary or appropriate.

Flexeril 10mg #30 with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril (Cyclobenzaprine).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, page(s) 63.

Decision rationale: The requested Flexeril 10 mg #30 with 1 refill is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of muscle relaxants for short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The request as it is submitted indicates that the use of this medication will be for longer than a duration of 2 to 3 weeks. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Flexeril 10 mg #30 with 1 refill is not medically necessary or appropriate.

Cyclo/Keto/Lido Cream 200gm with one refill.: 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.

Decision rationale: The requested Cyclo/Keto/Lido cream 200 gm with 1 refill is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of Cyclobenzaprine in a topical formulation as there is little scientific evidence to support the efficacy and safety of this medication as a topical agent. California Medical Treatment Utilization Schedule does not support the use of Ketoprofen in a topical formulation as it is not FDA approved to treat neuropathic pain. California Medical Treatment Utilization Schedule does not support the use of Lidocaine in a cream or gel formulation as it is not FDA approved to treat neuropathic pain in this formulation. As such, the requested Cyclo/Keto/Lido cream 200 gm with 1 refill is not medically necessary or appropriate.