

Case Number:	CM14-0088637		
Date Assigned:	07/23/2014	Date of Injury:	08/02/2013
Decision Date:	09/10/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	06/12/2014

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 Internal 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:

Patient is an injured worker with lumbosacral conditions. Date of injury was 08-02-2013. Primary treating physician report dated April 14, 2014 documented subjective complaints of lower back pain with radiculopathy in the left lower extremity with numbness, tingling, and weakness. He is currently working his usual and customary occupation; however, he does continue to be symptomatic. He has difficulty with his daily activities along with difficulty with prolonged periods of sitting, standing, walking, and stair climbing, as well as lifting, pushing, pulling, squatting, kneeling, and stooping. Physical examination was documented. Spasm, tenderness, and guarding is noted in the paravertebral muscles of the lumbar spine along with decreased range of motion. Decreased dermatomal sensation with pain is noted over the left L5 dermatome. The patient was authorized to proceed with second lumbar epidural injection, however, at this time, he declines further epidural injections. He wishes to proceed with chiropractic treatment which was provided to him previously and helped to reduce his pain, increase his functional capacity, help reduce the need for taking oral pain medications, and allowed him to be more functional in the work place. The patient was provided with four sessions of chiropractic treatment previously. Based on the above, I am requesting authorization for an additional eight sessions of chiropractic treatment to be provided to the patient on an industrial basis since his pain has recurred at this time. The above will help to reduce pain, increase musculoskeletal function, and avoid deconditioning. His medications will be refilled today. Lidocaine patches along with limited supply of therapeutic cream will also be provided for the patient, so that he could use locally to help reduce his pain, increase his functional capacity, and help reduce the need for taking oral pain medications. Diagnoses were lumbar disc displacement without myelopathy, and lumbosacral radiculopathy. Utilization review decision date was 05-15-2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Chiropractic Treatment x 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & Manipulation Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines Chiropractic treatment.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298,299,308,Chronic Pain Treatment Guidelines Chiropractic treatment , Manual Therapy & Manipulation Page(s): 30,58-60.

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address chiropractic treatment and manipulation. Manipulation is a passive treatment. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 6 visits should document objective functional improvement. Functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints addresses chiropractic treatment and manipulation. For patients with symptoms lasting longer than one month, efficacy has not been proved. Many passive and palliative interventions are without meaningful long-term benefit. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (page 308) states that prolonged course of manipulation (longer than 4 weeks) are not recommended. Primary treating physician report dated 04-14-2014 documented physical examination findings of spasm, tenderness, and guarding of the paravertebral muscles of the lumbar spine along with decreased range of motion, and decreased dermatomal sensation with pain over the left L5 dermatome. Work status is unchanged. Patient reported that he has difficulty with his daily activities along with difficulty with prolonged periods of sitting, standing, walking, and stair climbing, as well as lifting, pushing, pulling, squatting, kneeling, and stooping. No objective evidence of functional improvement, with clinically significant improvement in activities of daily living or a reduction in work restrictions, were documented. MTUS guideline requires objective functional improvement to justify extended chiropractic manipulation treatments. No objective functional improvements of activities of daily living or work restrictions were documented to support the request for 8 additional chiropractic treatments. Therefore, the request for additional chiropractic treatment x 8 is not medically necessary.

Refill Lidocaine Patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch), Topical Analgesics Page(s): 56-57, 111-112.

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines states that Lidoderm is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend Lidoderm for chronic neuropathic pain disorders other than post-herpetic neuralgia. Lidoderm (Lidocaine patch 5%) is not recommended for non-neuropathic pain. Medical records do not document a diagnosis of post-herpetic neuralgia. Per MTUS guidelines, Lidoderm is only FDA approved for post-herpetic neuralgia, and is not recommended for other chronic neuropathic pain disorders or non-neuropathic pain. Medical records and MTUS guidelines do not support the medical necessity of Lidoderm patch. Therefore, the request for refill of Lidocaine patches is not medically necessary.

Therapeutic Cream (Unspecified): Upheld

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

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

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Primary treating physician report dated April 14, 2014 documented that a supply of therapeutic cream will be provided for the patient. The specific ingredients were not documented. A therapeutic cream with unknown ingredients cannot be endorsed. Therefore, the request for therapeutic cream (unspecified) is not medically necessary.