

Case Number:	CM14-0190535		
Date Assigned:	11/24/2014	Date of Injury:	01/19/2014
Decision Date:	01/09/2015	UR Denial Date:	10/15/2014
Priority:	Standard	Application Received:	11/14/2014

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 Internal Medicine, has a subspecialty in Nephrology 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:

This is a 67-year-old female with a 1/19/14 date of injury. According to a progress report dated 9/22/14, the patient presented for a follow-up of back pain, currently rated as a 6-8/10 on the pain scale. She stated that her mid and low back pain continued to be severe and has increased somewhat over time. She reported radiation of pain and numbness down both lower extremities to her feet. She has completed 11 sessions of chiropractic therapy with some temporary relief. Objective findings: limited lumbar and thoracic range of motion, decreased sensation L4, L5, and S1 dermatomes on the right, pain with facet loading of lumbar spine. Diagnostic impression: lumbar radiculopathy, facet arthropathy of lumbar spine. Treatment to date: medication management, activity modification, chiropractic treatment, acupuncture, physical therapy. A UR decision dated 10/15/14 denied the requests for 8 visits of additional chiropractic treatment, CM4-CAPS 0.05% + cyclo 4%, follow-up visit, and open MRI of thoracic and lumbar spine. Regarding chiropractic treatment, 4 visits were authorized on 10/14/14, and the medical necessity of the request is not established. Regarding CM4-CAPS 0.05% + cyclo 4%, follow-up visit, and open MRI of thoracic and lumbar spine, a specific rationale for denial was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

(8) Visits of additional Chiropractic treatment for the back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

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

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that with evidence of objective functional improvement with previous treatment and remaining functional deficits, a total of up to 18 visits is supported. In addition, elective/maintenance care is not medically necessary. However, according to the UR decision dated 10/15/14, an additional 4 sessions of chiropractic treatment was authorized on 10/14/14. Evaluation of functional improvement from the authorized sessions is necessary prior to authorization for further treatment. It is noted that this patient has completed 11 sessions of chiropractic treatment. It is unclear why the patient would require 8 additional sessions at this time, as this would exceed guideline recommendations of up to 18 sessions. Therefore, the request for (8) Visits of additional Chiropractic treatment for the back was not medically necessary.

CM4-CAPS 0.05% + cyclo 4% lot# D1514@3: 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): 25, 28, 111-113.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in anything greater than a 0.025% formulation, Baclofen, Boswellia Serrata Resin, and other muscle relaxants, and Gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. However, in the present case, guidelines do not recommend Cyclobenzaprine or Capsaicin in anything greater than a 0.025% formulation for topical use. There is no documentation that this patient is unable to tolerate oral medications. A specific rationale identifying why this topical compounded medication would be required in this patient despite lack of guideline support was not provided. Therefore, the request for CM4-CAPS 0.05% + cyclo 4% lot# D1514@3 was not medically necessary.

Follow-up in 4 weeks: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Evaluations and management (E&M)

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

Decision rationale: ODG states that evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and make any necessary modifications to the treatment plan. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. However, in the present case, this patient reported severe pain that has been worsening. In addition, it is noted that 4 chiropractic therapy visits and an MRI of the thoracic and lumbar spine have been recently certified. A follow-up visit is appropriate to further evaluate the patient's condition, progress after chiropractic treatment, and review the results of the MRI. Therefore, the request for Follow-up in 4 weeks was medically necessary.

Open MRI of Thoracic and Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, Chronic Pain Treatment Guidelines Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRI

Decision rationale: CA MTUS supports imaging of the lumbar spine in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration for surgery. However, in the present case, there is no documentation of failure of conservative treatment. In fact, an additional course of chiropractic therapy has recently been authorized. In addition, according to the UR decision dated 10/15/14, an open MRI of the thoracic and lumbar spine was authorized on 9/25/14. It is unclear why this duplicate request is being made at this time. Therefore, the request for Open MRI of Thoracic and Lumbar Spine was not medically necessary.