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| Case Number: | CM14-0202476 | | |
| Date Assigned: | 12/15/2014 | Date of Injury: | 07/21/2013 |
| Decision Date: | 02/05/2015 | UR Denial Date: | 11/06/2014 |
| Priority: | Standard | Application Received: | 12/03/2014 |

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 23 year old employee with date of injury of 7/21/13. Medical records indicate the patient is undergoing treatment for lumbar radiculopathy, lumbar herniated disc and muscle spasm. Subjective complaints include chronic mid to low back pain. The patient rates her pain as 7/10. The pain is described as pinching and stabbing with pressure and numbness which radiates to her right leg. Her symptoms are aggravated by sitting, standing, walking, bending and lifting. She gets relief from heat, ice and physical therapy. The patient states that after receiving an epidural steroid injection her pain was reduced to a 3/10 (from 7/10) for 3 months, however her pain has now returned. Objective findings include reduced range of motion in the lumbar spine. There is tenderness at the facets and positive straight leg raise. Her gait is antalgic. Reflexes are reduced at the right knee. She has bilateral paraspinal muscle tenderness and limited flexion and extension of the lumbar spine. Treatment has consisted of physical therapy x 8 sessions (2013), physical therapy x 12 sessions (9/2014), epidural steroid injection (8/21/14), Zanaflex, Robaxin, Naproxen and a topical cream and patch. The utilization review determination was rendered on 11/6/14 recommending non-certification of Additional Physical Therapy time 12 sessions and Gab/Lid/Aloe/Cap/Men/Cam (Patch) 10% 2% 5% .025% 10% 5% gel quantity 120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physical Therapy times 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Physical Therapy and Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar and Thoracic (Acute and Chronic), Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. The patient has tried two courses of physical therapy with no documented improvement and has had over 30 PT visits and exceeds the number of visits per the ODG guidelines. As such, the request for Additional Physical Therapy times 12 sessions is not medically necessary.

Gab/Lid/Aloe/Cap/Men/Cam (Patch) 10% 2% 5% .025% 10% 5% gel quantity 120:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams

Decision rationale: MTUS and ODG recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "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." MTUS states that topical Gabapentin is "Not recommended." And further clarifies, "anti-epilepsy drugs: There is no evidence for use of any other anti-epilepsy drug as a topical product." As such, the request for Gab/Lid/Aloe/Cap/Men/Cam (Patch) 10% 2% 5% .025% 10% 5% gel quantity 120 is not medically necessary.