

Case Number:	CM15-0184741		
Date Assigned:	09/25/2015	Date of Injury:	03/01/2014
Decision Date:	11/23/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/21/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 38 year old female with a date of injury on 3-1-2014. A review of the medical records indicates that the injured worker is undergoing treatment for degeneration of lumbar intervertebral disc with myelopathy, lumbar sprain-strain, right and left carpal tunnel syndrome, right and left DeQuervain's disease, anxiety and depression. According to the progress report dated 8-17-2015, the injured worker complained of intermittent sharp low back pain rated four out of ten. She complained of intermittent, achy sharp pain in the bilateral wrists and loss of sleep due to pain. The physical exam (8-17-2015) revealed decreased range of motion of the lumbar spine and the bilateral wrists. Phalen's caused pain bilaterally. Treatment has included acupuncture, CMT-Physiotherapy and medications. The request for authorization dated 8-17-2015 included acupuncture 2 x per week for 3 weeks; chiropractic 2 x per week for 3 weeks; Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in cream base; Flurbiprofen 20%, Baclofen 10%, Dextromethorphan 2% in cream base; Ultram; urinalysis and Terocin patches. The original Utilization Review (UR) (8-27-2015) denied acupuncture for the bilateral wrists; chiropractic treatment to include physiotherapy, CMT for the bilateral wrists; Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in cream base; Flurbiprofen 20%, Baclofen 10%, Dextromethorphan 2% in cream base and Terocin patches. Utilization Review approved a urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture for bilateral wrists 2 times a week for 3 weeks, quantity: 6 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Acupuncture.

Decision rationale: Regarding the request for additional acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions" and a reduction in the dependency on continued medical treatment. A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it appears the patient has undergone acupuncture previously. It is unclear how many sessions have previously been provided. Additionally, there is no documentation of sustained objective functional improvement from the therapy already provided. As such, the currently requested acupuncture is not medically necessary.

Chiropractic treatment to include physiotherapy, CMT for bilateral wrists 2 times a week for 3 weeks, quantity: 6 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: Regarding the request for additional chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, there is documentation of completion of prior chiropractic sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In the absence of clarity regarding the above issues, the currently requested chiropractic care is not medically necessary.

Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in cream base, quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in cream base, quantity: 1, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. Guidelines do not support the use of topical antidepressants. As such, the currently requested Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in cream base, quantity: 1 is not medically necessary.

Flurbiprofen 20%, Baclofen 10%, Dextromethorphan 2% in cream base, quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Flurbiprofen 20%, Baclofen 10%, Dextromethorphan 2% in cream base, quantity: 1, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants drugs are not supported by the CA MTUS for topical use. As such, the currently requested Flurbiprofen 20%, Baclofen 10%, Dextromethorphan 2% in cream base, quantity: 1 is not medically necessary.

Terocin patches, quantity: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Terocin, Terocin is a combination of methyl salicylate, menthol, lidocaine and capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Regarding the use of topical nonsteroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been

inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards, or with the diminishing effect over another two-week period. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical lidocaine, guidelines the state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Finally, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested Terocin is not medically necessary.