

Case Number:	CM15-0197986		
Date Assigned:	10/13/2015	Date of Injury:	03/20/2014
Decision Date:	12/23/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	10/08/2015

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 28 year old woman sustained an industrial injury on 3-20-2014. Diagnoses include lumbar spine musculoligamentous sprain-strain with radiculitis rule out lumbar spine discogenic disease, bilateral hip sprain-strain versus lumbar radiculitis and right hip bursitis, bilateral knee sprain-strain versus lumbar radiculitis, bilateral ankle sprain-strain, and bilateral foot plantar fasciitis. Treatment has included oral medications and chiropractic care. Physician notes dated 7-22-2015 show complaints of low back pain rated 4-5 out of 10 (improved from 8 out of 10), and right knee, right hip, and bilateral ankles-feet pain rated 5 out of 10 (improved from 7 out of 10). However, the left hip pain is rated 5 out of 10 which remains the same) and the left knee pain is rated 3 out of 10 (which has increased). The physical examination shows grade two tenderness on palpation of the paraspinal muscles of the lumbar spine, bilateral hips, bilateral knees, bilateral ankles, and bilateral feet. "Restricted" range of motion is noted in the lumbar spine without measurements. Recommendations include continue chiropractic care, Tramadol, Theramine, Flurbinap cream, and follow up in six weeks. Utilization Review denied requests for chiropractic care, Tramadol, Theramine, and Flurbiprofen cream on 7-22-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy for the lumbar spine and bilateral knees, twice a week for five weeks: Upheld

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

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

Decision rationale: California MTUS Guidelines state that chiropractic treatments are recommended for chronic pain caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. For the low back, the MTUS recommends 6 visits over two weeks as part of a clinical trial of manual therapy, with up to 18 visits over 6-8 weeks with evidence of objective functional improvement. The California MTUS does not address cervical spine manual therapy. According to the ODG, manual therapy to the cervical spine can be considered for cervical nerve root compression with radiculopathy, patient selection based on previous chiropractic success, and with frequency recommendation of a trial of six visits over 2-3 weeks. Manual therapy is not recommended for knee complaints. Furthermore, in review of the medical records, it appears that past manual therapy provided minimal relief overall. The necessity for continued manual therapy has not been established. The request is not medically necessary.

Tramadol 50mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: The California MTUS guidelines allows for the use of opioid medication, such as Tramadol, for the management of chronic pain and outlines clearly the documentation that would support the need for ongoing use of an opioid. These steps include documenting pain and functional improvement using validated measures at 6 months intervals, documenting improvement in participation of activities of daily living, documenting the presence or absence of any adverse effects, documenting the efficacy of any other treatments and of any other medications used in pain treatment, and discussion of monitoring for aberrant drug taking behavior (The 4 A's - Analgesia, Activities of Daily Living, Aberrant drug taking behavior, Adverse side effects). Within the records submitted, there is ongoing pain, rated in the moderate to severe range dating back to 2014 despite chronic medication use. The 4 A's have not been clearly demonstrated and thus, applicable guideline criteria has been met. This request is not medically necessary.

Theramine quantity 90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Work Loss Data Institute, Pain (Chronic) Chapter, Theramine.

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

Decision rationale: ODG states that Theramine is intended for use in the management of pain syndromes that include acute pain, chronic pain, fibromyalgia, neuropathic pain, and inflammatory pain. Until there are higher quality studies of the ingredients in Theramine, it remains not recommended. This medical food is not supported by the ODG and there are no extenuating circumstances to warrant use. As such, the request is not medically necessary.

Flurbiprofen (NAP) cream-LA quantity 180gm: Upheld

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

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

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. The topical compound noted above contains a topical NSAID Flurbiprofen, Lidocaine, and Amitriptyline. Lidocaine is only approved for topical use in patch form and the MTUS does not support topical Amitriptyline use. As such, this request is not medically necessary.