

Case Number:	CM15-0046708		
Date Assigned:	03/19/2015	Date of Injury:	08/18/2011
Decision Date:	05/11/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	03/12/2015

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, Florida, Illinois
 Certification(s)/Specialty: Emergency Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 62-year-old female who reported an injury on 08/18/2011. The mechanism of injury was lifting. She was diagnosed with lumbar radiculopathy. Her past treatments are noted to include physical therapy, acupuncture, work restrictions, spinal injections, medications, and cognitive behavioral therapy. The injured worker's symptoms were noted to include lower back pain with radiating symptoms to the bilateral lower extremities. It was noted that she takes medications for pain which allow her to function. Physical examination findings included tenderness to palpation of the paravertebral muscles, decreased sensation in the bilateral S1 dermatomes, and positive straight leg raising bilaterally. The treatment plan included continued medications and a course of chiropractic therapy. The injured worker's medications were noted to include omeprazole 20 mg daily, orphenadrine ER 100 mg twice daily, Norco 10/325 mg twice daily, naproxen 550 mg daily, and Voltaren 1% gel to be applied twice a day. A specific rationale for Voltaren, orphenadrine ER, and Norco was not provided. The chiropractic care was recommended due to the exacerbation of her lower back pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1 Percent Gel: Upheld

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

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

Decision rationale: The California MTUS Guidelines state Voltaren topical gel is recommended for relief of osteoarthritis pain and joints that amend themselves to topical treatment such as the ankle, elbow, foot, hand, knee, or wrist. The guidelines also specifically state that this topical medication has not been evaluated for treatment of the spine, hip, or shoulder. The clinical information submitted for review indicated that the injured worker had symptoms of the low back with radiating pain into the bilateral lower extremities. As this medication has not been evaluated for treatment of the spine, Voltaren gel is not supported for this injured worker. In addition, the guidelines specifically state topical NSAIDs are not recommended for neuropathic pain as there is no evidence to support use. Additionally, the request as submitted did not include a quantity or frequency of use. For these reasons, the request is not medically necessary.

Orphenadrine ER 100 MG #60 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: According to California MTUS Guidelines, nonsedating muscle relaxants are recommended with caution as a second line option for the short term treatment of acute exacerbations in patients with chronic low back pain. The clinical information submitted for review indicated that the injured worker has been utilizing orphenadrine ER since at least 06/05/2014. Therefore, continued use would not be supported as the guidelines only recommend short term use of these medications. In addition, the injured worker was noted to report improved function with her medications. However, there was no documentation to support quantified pain relief with use of this medication. There was also no documentation indicating that she had significant muscle spasm which was relieved by use of this medication. Moreover, the request for 2 refills would not allow for adequate reassessment prior to continuing this treatment and the request as submitted did not include a frequency. For these reasons, the request is not medically necessary.

Hydrocodone (Norco)/APAP 10/325 MG #60 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management Page(s): 78.

Decision rationale: According to the California MTUS Guidelines, the ongoing management of patients taking opioid medications should include detailed documentation of pain relief, functional status, adverse side effects, and appropriate medication use. The clinical information submitted for review indicated that the injured worker has been using Norco since at least 06/05/2014. It was noted that she had improved function with use of this medication. However, details regarding her functional improvement were not provided. Additionally, there was no documentation of quantified pain relief to support continued use of Norco. The documentation also did not address whether she had significant adverse side effects or aberrant behavior. There was also no evidence of consistent results on a recent urine drug screen to confirm appropriate medication use. For these reasons, continued use of Norco is not supported by the guidelines. In addition, the request for 2 refills would not allow for adequate reassessment prior to continuing with this medication and the request as submitted did not include frequency. For these reasons, the request is not medically necessary.

Chiropractic Care 3 Times A Week for 4 Weeks for Back and Bilateral Lower Extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-59.

Decision rationale: According to the California MTUS Guidelines, manual therapy and manipulation is recommended for chronic pain caused by musculoskeletal conditions to obtain objective measurable gains and functional improvement and facilitate progression in an active therapeutic exercise program. For low back conditions, a trial of 6 visits over 2 weeks is recommended for appropriate patients. Following the trial, a total of up to 18 visits may be recommended with evidence of objective functional improvement. The clinical information submitted for review indicated that chiropractic therapy was recommended for the injured worker due to an exacerbation of her lower back pain. The California MTUS Guidelines state that chiropractic therapy may be recommended for recurrences and flare ups of low back pain after initial treatment with chiropractic therapy resulted in objective functional improvement. The clinical information submitted for review indicated that the injured worker had not had prior treatment with chiropractic therapy for her condition. She was noted to have chronic low back pain. However, recent physical examination failed to show evidence of objective functional deficits to warrant chiropractic treatment. In addition, the documentation did not indicate that this treatment would coincide with more active treatment programs per the guidelines. Furthermore, the request for visits 3 times weeks for 4 weeks would exceed the guidelines recommendation for initial 6 visit trial. For these reasons, the request is not medically necessary.