

Case Number:	CM15-0051489		
Date Assigned:	03/24/2015	Date of Injury:	10/22/2014
Decision Date:	05/04/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/18/2015

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: Texas, Florida
 Certification(s)/Specialty: Anesthesiology, 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:

The injured worker is a 44 year old female, who sustained an industrial injury on 10/12/2014. She reported a back injury from mopping. The injured worker was diagnosed as having lumbar sprain/strain and lumbosacral spondylosis. A recent x rays reveal lumbosacral instability and anterolisthesis of L5 on S1. Treatment to date has included physical therapy and medications management. Currently, the injured worker complains of low back pain associated with bilateral legs weakness. In a progress note dated 2/21/2015, the treating physician is requesting acupuncture, chiropractic care, compounded cream, EMG/NCV studies and MRI of the lumbar spine. The IW was noted to be refractory to medications management and PT. The medications listed are Flurbiprofen / Lanzoprazole and topical compound cream containing gabapentin for neuropathic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 10%/lidocaine 10%/gabapentin 6%, 240gm;: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines California Code of Regulations 9792.6, Title 8.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain ChapterCompound topical cream.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesic products can be utilized for the treatment of localized neuropathic pain when treatment with first line oral anticonvulsant and antidepressant medications have failed. The recommended second line medication is topical plain lidocaine products such as Lidoderm. The records did not show subjective or objective findings consistent with a diagnosis of localized neuropathic pain such as CRPS. There is no documentation of failure of oral formulations of first line medications. The guidelines recommend that topical products be tried and evaluated individually for efficacy. There is lack of guidelines or FDA support for the utilization of non oral formulations of gabapentin. The patient is utilizing oral formulation of NSAIDs concurrently increasing the risk of NSAIDs related adverse effects. The criteria for the use of Furbiprofen 10% / lidocaine 10%/ gabapentin 6% in 240 grams was not met. The request is not medically necessary.

Acupuncture 2x4, lumbar spine,: Overturned

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

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

Decision rationale: The CA MTUS-Acupuncture and the ODG guidelines recommend that acupuncture treatments can be utilized for the management of musculoskeletal pain. The utilization of acupuncture can be result in pain relief, increase in range of motion and decrease in medications utilization. The records indicate that the patient was noted to be refractory to medications and PT. The severity of the back pain had not significantly decreased despite medications management and PT. The criteria for 2 X 4 Acupuncture treatments for lumbar spine was met. The request is medically necessary.

Chiro 2x4, Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines California Code of Regulations 9792.6, Title 8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment, Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 12 Low Back Complaints Page(s): 22, 46-47, 96-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain ChapterLow and Upper Back.

Decision rationale: The CA MTUS-ACOEM and the ODG guidelines recommend that Physical Treatments that includes Chiropractic treatment can be utilized for the management of exacerbation of musculoskeletal pain. The use of chiropractic treatment can result in reduction in

pain and medication utilization and improvement in range of motion of the joints. The records indicate that the patient did not report significant pain relief following prior PT management. There is radiological documentation of instability of the lumbar spine that can be further aggravated by passive treatment measures. The records indicate that recommendations for further investigations with MRI and EMG/NCV studies is pending authorization. The criteria for 2 X 4 Chiropractic Treatments of the lumbar spine was not met. The request is not medically necessary.