

Case Number:	CM15-0051656		
Date Assigned:	03/25/2015	Date of Injury:	09/01/2014
Decision Date:	05/14/2015	UR Denial Date:	02/11/2015
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: California, Washington

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:

The injured worker is a 45-year-old male who reported an injury on 09/01/2014. The mechanism of injury was not specifically stated. The injured worker is currently diagnosed with thoracic sprain and lumbar sprain. On 02/04/2015, the injured worker presented for a follow-up evaluation with complaints of persistent thoracic and lumbar spine pain with numbness and tingling. The injured worker reported a relief of symptoms with massage and physical therapy. Upon examination, there was no evidence of swelling, atrophy, or a lesion at the thoracic or lumbar spine. Recommendations included a continuation of chiropractic therapy, LINT for the lumbar spine, acupuncture, and continuation of the current medication regimen. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2 times a week for 6 weeks to lumbar and thoracic spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated and may be used as an adjunct to physical rehabilitation and/or surgical intervention. The time to produce functional improvement includes 3 to 6 treatments. The current request for 12 sessions of acupuncture greatly exceeds guideline recommendations. There was also no documentation of a musculoskeletal deficit upon examination. Given the above, the request is not medically appropriate.

Flurbiprofen 20%, Baclofen 10%, Dexamethasone 2% in cream base #1: Upheld

Claims Administrator 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).

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

Decision rationale: The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. Muscle relaxants are not recommended for topical use. There was also no frequency listed in the request. Given the above, the request is not medically appropriate.

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

Claims Administrator 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).

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

Decision rationale: The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. Gabapentin is not recommended as there is no peer reviewed literature to support its use as a topical product. There was also no frequency listed in the request. As such, the request is not medically appropriate.

Localized neurostimulation therapy 1 time a week for 3 weeks, lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PENS Page(s): 97.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state physical modalities, such as cutaneous laser treatment, massage, diathermy, ultrasound therapy, and TENS therapy have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies. Therefore, the request cannot be determined as medically appropriate at this time.