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| Case Number: | CM15-0113433 | | |
| Date Assigned: | 06/19/2015 | Date of Injury: | 05/13/2010 |
| Decision Date: | 07/20/2015 | UR Denial Date: | 05/21/2015 |
| Priority: | Standard | Application Received: | 06/11/2015 |

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 61 year old female, who sustained an industrial injury on 05/13/2010. She reported she was attempting to pull a table when it came down on top of her causing her to land in the seated position. The injured worker was diagnosed as having protrusion with neural encroachment, lumbar radiculopathy, annular tear at lumbar four to five, remote cervical fusion, and rule out cervical disc injury. Treatment and diagnostic studies to date has included magnetic resonance imaging of the lumbar spine, medication regimen, use of a transcutaneous electrical nerve stimulation unit, use of a lumbosacral orthosis, magnetic resonance imaging of the cervical spine, status post pre-existing anterior cervical fusion and discectomy, and physical therapy. In a progress note dated 04/14/2015 the treating physician reports complaints of pain to the low back radiating to the lower extremities with the left greater than the right, pain to the cervical spine that radiates to the bilateral upper extremities with the left greater than the right, pain to the right ankle, and headaches. Examination reveals tenderness to the cervical spine, lumbar spine, and the right ankle, decreased range of motion to the lumbar spine, positive straight leg raise, diminished sensation to the bilateral lower extremities with the left greater than the right, decreased strength to the bilateral upper extremities, and painful range of motion to the right ankle. The injured worker's current medication regimen includes Hydrocodone and Flexeril. The treating physician also noted prior use of a topical anti-epileptic drug that was noted to decrease pain by 50% to radicular symptoms of the cervical and lumbar spine along with noted improvement in tolerance of standing and walking by 30%. The injured worker's current pain level is rated an 8 out of 10 to the low back, a 5 out of 10 to the cervical spine to the

bilateral upper extremities, and a 5 out of 10 with right ankle pain, but the documentation provided did not indicate the injured worker's pain level as rated on a pain scale prior to use of her medication regimen and after use of her medication regimen to indicate the effects with the use of her current medication regimen. Also, the documentation provided did not indicate if the injured worker experienced any functional improvement with use of her current medication regimen. The treating physician requested the medication of Gabapentin 6% in base with a quantity of 300 grams noting a successful trial of topical antiepileptic drug and assisted in diminishing the radicular pain to the cervical and lumbar spine. The treating physician also requested chiropractic therapy for the lumbar spine three times weekly for four weeks indicating no prior chiropractic therapy and indicating treatment for active therapy in conditioning and strengthening. The treating physician requested a lumbosacral orthosis back brace noting current use of this equipment along with noting that it improves tolerance to standing and walking.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiro for the lumbar spine, three times weekly for four weeks: Upheld

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

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

Decision rationale: According to MTUS guidelines, Manual therapy & manipulation "Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care Not medically necessary. Recurrences/flare-ups Need to reevaluate."Based on the patient's records, there is no functional deficits documented that could not be addressed with home exercise program. In addition, the frequency of the treatment should be reduced from 12 to 3 or less sessions. More sessions will be considered when functional and objective improvement are documented. Therefore, the request for 12 chiropractic sessions for the lumbar spine is not medically necessary.

New LSO back brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: According to MTUS guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. A lumbar corset is recommended for prevention and not for treatment. Therefore, the request for custom fit Lumbar Brace is not medically necessary.

Gabapentin 6% in base, 300 grams apply three grams TID-QID: 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.

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The proposed topical analgesic contains Gabapentin, a topical analgesic that is not recommended by MTUS. Based on the above, the request for Gabapentin 6% in base, 300 grams is not medically necessary.