

Case Number:	CM15-0039424		
Date Assigned:	03/09/2015	Date of Injury:	04/13/2010
Decision Date:	04/20/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	03/02/2015

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 50 year old female, who sustained an industrial injury on April 13, 2010. She has reported neck pain radiating to the left shoulder, lower back pain radiating to the bilateral knees and feet, and sleep difficulties. Diagnoses have included displacement of cervical spine intervertebral disc, displacement of lumbar spine intervertebral disc, cervical spine radiculitis, and lumbosacral radiculitis. Treatment to date has included medications. A progress note dated January 12, 2015 indicates a chief complaint of neck pain radiating to the left shoulder, lower back pain radiating to the bilateral knees and feet with numbness and tingling, and sleep difficulties. The pain score was rated at 6/10 on a scale of 0 to 10. There were objective findings of tenderness to the cervical paraspinal muscles but no sensory or motor abnormality. The treating physician documented a plan of care that included chiropractic treatments, topical pain creams, and a magnetic resonance imaging of the lumbar spine. A Utilization Review determination was rendered recommending non certification for Chiropractic treatments X3 per week for 8 weeks, FCL cream 180grms and MRI of the Lumbar Spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic, three times weekly for eight weeks, twenty-four visits total: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 22, 46-47, 96-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Physical Treatments.

Decision rationale: The CA MTUS and the ODG guidelines recommend that physical therapy treatments can be utilized in the management of exacerbation of musculoskeletal pain that did not respond to standard treatment with NSAIDs. The records did not show subjective and objective findings consistent with exacerbation of musculoskeletal pain. There was no documentation of progressive neurological or physical deficits. It is noted that care of the IW is being transferred to another Provider who will determine a future treatment plan. The criteria for Chiropractic treatment x3 per week for 8 weeks was not met.

FCL topical cream (Flurbiprofen 20%/Cyclobenzaprine 4%/Lidocaine 5%) 180 grams:
Upheld

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

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 Chapter Topical analgesics.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesic products can be utilized for the treatment of localized neuropathic pain that did not respond to standard treatment with first line anticonvulsant and antidepressant medications. The records did not show subjective or objective findings consistent with a diagnosis of localized neuropathic pain such as CRPS. The guidelines recommend that topical products be utilized individually for evaluation of efficacy. There is lack of guidelines or FDA support for the utilization of topical formulations of cyclobenzaprine. The criteria for the use of FCL topical cream - Flurbiprofen 20%, cyclobenzaprine 4% lidocaine 5% 180 grams was not met.

MRI of the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRI Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low and Upper Back.

Decision rationale: The CA MTUS and the ODG guidelines recommend that MRI investigation can be utilized in the evaluation of exacerbation of musculoskeletal pain associated with

neurological deficits or in the presence of a 'red flag' condition. The records did not show subjective and objective findings consistent with exacerbation of musculoskeletal pain with progressive neurological or physical deficits. There was documentation of limited objective findings in the physical examination related to the lumbar spine. It is noted that care of the IW is being transferred to another Provider who will determine a future treatment plan. The criteria for MRI of the lumbar spine was not met.