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| Case Number: | CM15-0123443 | | |
| Date Assigned: | 07/15/2015 | Date of Injury: | 06/10/2009 |
| Decision Date: | 10/02/2015 | UR Denial Date: | 06/10/2015 |
| Priority: | Standard | Application Received: | 06/26/2015 |

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 York
 Certification(s)/Specialty: Pediatrics, Internal 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 33 year old male, who sustained an industrial injury on June 10, 2009. The mechanism of injury is not documented. The injured worker was diagnosed as having lumbar radiculopathy, lumbar sprain-strain and insomnia. Treatment to date has included oral medications including Ibuprofen 800mg, Cyclobenzaprine 7.5mg and Norco 10-325mg; topical medications including Terocin patch, Flurbiprofen-Baclofen-Dextromethorphan and Gabapentin-Amitriptyline-Bupivacaine and activity restrictions. Currently on April 21, 2015, the injured worker complains of intermittent constant sharp and throbbing low back pain rated 7-10 and relieved with medication. He also notes feeling stress and has difficulty sleeping. Of note, documented pain levels are 12-22-14 (10-10), 1-21-15 (6-10) and 3-24-15 (7-10). The injured worker is currently not working. Physical exam performed on April 21, 2015 revealed restricted range of motion of lumbar spine and pain with straight leg raise. The treatment plan included prescriptions for Prilosec DR 20mg, Cyclobenzaprine 7.5mg, Anaprox DS 550mg, Flurbiprofen-Baclofen-Dextromethorphan, Gabapentin-Amitriptyline-Bupivacaine, Norco 10-325mg, and epidural steroid injections of lumbar spine, acupuncture, 12 Chiropractic Manipulative treatments-physiotherapy sessions and a urinalysis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiro 2x3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

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

Decision rationale: Per the MTUS chronic pain section, a trial of 6 visits of manual therapy and manipulation may be provided over 2 weeks for low back pain; further treatments are contingent on functional improvement. Chiropractic treatments have previously been ordered, however documentation does not indicate if they were provided and if they were provided, there is no indication of functional improvement, increased strength or increased range of motion. The progress notes included note an unchanged medical condition. Chiropractic treatments were requested to increase strength and range of motion. The request for chiropractic treatments is not medically necessary.

Epidural Injection L2-S1 levels: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter - ESI.

Decision rationale: Per MTUS guidelines recommended epidural steroid injections (ESI) as an option for treatment of radicular pain. Criteria for ESI are that the radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Injections should be performed using fluoroscopy (live x-ray) for guidance. If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. No more than two nerve root levels should be injected using transforaminal blocks. There is no documentation of a radiculopathy on clinical exam nor on EMG/NCV. Additionally, there is a lack of evidence of prior treatment modalities utilized and failed. Lastly, the request is for L2 through S1 and this far exceeds the recommendation of injecting no more than 2 levels at one time. This request is not medically necessary and reasonable.

Flurbiprofen 20%/Baclofen 10%/Dextromethorphan 2% in a cream base 30 day supply: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines (2009), Topical Analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Topical analgesics are also indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Per MTUS guidelines, Baclofen is not recommended for topical use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Dexamethasone and flurbiprofen are not FDA approved for topical use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. This request is not medically necessary and appropriate.

Ultram/Tramadol HCL 150mg #30 1 tab daily: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol; opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The medication requested for this patient is Ultram (Tramadol). According to the California MTUS, Tramadol is a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain, with any opioid, requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. According to the medical documentation, there has been no indication of the medication's pain relief effectiveness and no clear documentation that the patient has responded to ongoing opioid therapy. Per California MTUS Guidelines, there have to be certain criteria followed, including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient may require a multidisciplinary evaluation to determine the best approach to treatment of her chronic pain syndrome. The injured worker has not returned to work. Per the documentation dated 4-21-15, Ultram is not requested on the treatment plan. Medical necessity for the requested medication has not been established. The requested treatment with Ultram is not medically necessary.

Acupuncture 2x3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: CA MTUS guidelines recommend Acupuncture as an option when pain medication is reduced or not tolerated. It may be used with physical therapy or to accelerate functional recovery following surgery. "Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient and reduce muscle spasm." The frequency and duration of treatments may be performed as follows: 3-6 treatments to produce functional improvement, 1-3 times per week for 1-2 months. With the documentation of functional improvement, acupuncture treatments may be extended. The request for acupuncture is to decrease inflammation and increase circulation. Documentation does not support prior acupuncture treatments were effective in allowing a decrease in pain medication. Therefore, the request for acupuncture treatments is not medically necessary.

Gabapentin 10%/Amitriptyline 10%/Bupivacaine 5% in a cream base 30 day supply:
Upheld

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

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

Decision rationale: According to the California MTUS Guidelines (2009), Topical Analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (for example including, non-steroidal anti-inflammatory drugs (NSAIDs), opioids, capsaicin, muscle relaxants, local anesthetics and/or antidepressants). Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic compound contains: Gabapentin 10%-Amitriptyline 10%-Bupivacaine 5%. In this case, there is no documentation provided necessitating this compounded topical analgesic. There is no documentation of intolerance to other previous oral medications. Bupivacaine, amitriptyline, and gabapentin are not FDA approved for topical use. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.