

Case Number:	CM13-0021663		
Date Assigned:	11/13/2013	Date of Injury:	04/14/2000
Decision Date:	02/13/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and has a subspecialty in Pulmonary Diseases and is licensed to practice in <MPR ST LICENSE>. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 52-year-old male who sustained a work-related injury on 04/14/2000. the patient's diagnoses included grade I retrolisthesis at L5-S1, moderate disc collapse at L4-5 and L5-S1 with mild spondylosis, L4-5 herniated nucleus pulposus, and right lower extremity radicular pain with paresthesia. Subjectively, the patient reported complaints of continuous lower back pain with radiation into the bilateral lower extremities. The patient reported episodes of numbness and tingling in the bilateral lower extremities. The patient rated his pain in the lumbar spine as 2-3/10. Physical examination of the lumbar spine revealed tenderness to palpation, decreased range of motion, positive straight leg raise, and positive Braggard's test. Neurologically, the patient had a sensory deficit on the right at L5-S1, a positive Valsalva test, decreased motor strength, and depressed deep tendon reflexes. Request for authorization was made for the following: topical analgesics, MRI of the lumbar spine, Motrin, Prilosec, a multi-stim unit, Solar Care FIR heating system, and a Kronos lumbar spine pneumatic brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription Motrin: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, hypertension and renal function Page(s): 69-72.

Decision rationale: CA MTUS guidelines indicate that Motrin is recommended for use in osteoarthritis and off-label for ankylosing spondylitis and mild to moderate pain but sufficient clinical improvement should be observed to offset potential risk of treatment with the increased dose...NSAIDs can increase blood pressure in patients with hypertension and may cause fluid retention, edema, and rarely, congestive heart failure as such it is recommended with caution. The patient was noted to have an elevated blood pressure on physical examination indicative of uncontrolled hypertension. Furthermore, the clinical provided lacks documentation of duration of use or effective pain reduction with the requested medication. Given the above, the request for prescription Motrin is non-certified.

Prescription Prilosec: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: CA MTUS Guidelines state "proton pump inhibitors such as omeprazole are indicated in the treatment of NSAID-induced dyspepsia." The clinical provided fails to establish the presence of dyspepsia either NSAID-induced or stand alone. As such, the request is not supported. Therefore, the request for prescription Prilosec is non-certified.

Prescription Flurbiprofen 20% gel: 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): 111-112.

Decision rationale: CA MTUS guidelines indicate that "the only FDA approved NSAID agent for topical use is Voltaren Gel 1%." Flurbiprofen is an NSAID and is not recommended for topical use per guidelines or the FDA. Additionally, the clinical provided lacks subjective documentation of medication efficacy to warrant the continued use. As such, the request cannot be validated. Therefore, the request for prescription flurbiprofen 20% gel is non-certified.

Ketoprofen 20%/Ketamine 10% gel: 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): 111-113.

Decision rationale: California MTUS Guidelines do not recommend the use of ketamine in a topical formulation as it is under study and is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Additionally, the only FDA-approved NSAID agent for topical use is Voltaren gel 1%. Given that ketoprofen is an NSAID, its use is not recommended in topical formulation. As such, the request for ketoprofen 20%/ketamine 10% gel is non-certified.

Prescription gabapentin 10%/cyclobenzaprine 10%/capsaicin 0.0375%: 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): 111-113.

Decision rationale: CA MTUS guidelines indicate that there have been no studies of a 0.0375% formulation of capsaicin, and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Gabapentin is not recommended for topical use as there is no peer-reviewed literature to support use, and guidelines further do not recommend muscle relaxants in topical formulation as there is no evidence to support their use. Given guidelines indicate if 1 of the medications in the compound is not recommended, then the compound as a whole cannot be recommended, the request for the compound cannot be validated. Additionally, there is lack of documentation of medication efficacy to warrant its continued use. As such, the request for prescription gabapentin 10%, cyclobenzaprine 10%/capsaicin 0.0375% is non-certified.

Pro-Tech Multi Stim Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114.

Decision rationale: CA MTUS guidelines do not recommend the use of TENS units in chronic pain as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The clinical provided lacks documentation of evidence to support that the patient is enrolled in an active physical therapy program to warrant the use of a TENS unit as an adjunct treatment. Additionally, guidelines support the use of active modalities over passive modalities. As such, the request for Pro-Tech multi-stim unit is non-certified.

Solar Care FIR heating system: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) regarding heat therapy for the back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Infrared therapy (IR).

Decision rationale: Official Disability Guidelines indicates that Infrared therapy (IR) is Not recommended over other heat therapies, and in cases where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP (low back pain), but only if used as an adjunct to a program of evidence-based conservative care (exercise). The clinical provided indicates the patient's back pain is chronic in nature and there are no objective findings to indicate there is an acute flare-up of symptoms. Additionally, there is lack of documentation to indicate the patient is in an active physical therapy program to support a limited trial of IR therapy as an adjunct treatment. As such, the request for Solar Care FIR heating system is non-certified.

Kronos lumbar spine pneumatic brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) regarding lumbar supports.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports.

Decision rationale: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP... For treatment of nonspecific LBP, compared with no lumbar support, an elastic lumbar belt may be more effective than no belt at improving pain and at improving functional capacity. While the clinical provided indicates the patient has chronic low back pain, there is no objective documentation of instability or fracture to warrant the need for a back brace over an elastic belt. As such, the request for Kronos lumbar spine pneumatic brace is non-certified.