

Case Number:	CM13-0041628		
Date Assigned:	12/20/2013	Date of Injury:	09/09/2009
Decision Date:	05/05/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/14/2013

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 Physical Medicine & Rehabilitation, and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 43-year-old male with a date of injury of 04/01/2005. The mode of injury was not noted in the medical documentation. The injured worker has diagnoses of status post interlaminar laminectomy to the left L5-S1, disc protrusion at C4-5 and C5-6 with stenosis as well as cervical spine, thoracic spine and lumbar spine myofascial pain syndrome. The injured worker was seen on 08/27/2013 with complaints of constant neck pain. The pain level was a 7/10 with radiation to the bilateral upper extremities with numbness and tingling in both hands. The injured worker also had complaints of low back pain with a pain level of an 8/10 with radiation to the bilateral lower extremities, down to the heel. The injured worker reported constant bilateral shoulder pain with a pain level of 7/10 with weakness and limited range of motion as well as bilateral thumb and elbow pain. The injured worker also has complaints of bilateral wrist/hand pain with a pain rating of 7/10 and numbness and tingling noted. Current medications include flurbiprofen 20% gel, ketoprofen 20%/ketamine 10% gel and gabapentin 10%/cyclobenzaprine 10%/capsaicin 0.0375% gel. On physical exam, the physician stated that the bilateral upper extremity strength was a 4/5 and 5/5. There was decreased sensation in the C5-6 distribution with all other dermatomes intact. The physician's treatment plan was to continue with psychiatric followup. Medications were refilled, and a request for authorization for aquatic therapy for the cervical and lumbar spines was made. The injured worker had declined to undergo anterior cervical decompression and fusion surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

SIX (6) SESSIONS OF SHOCKWAVE THERAPY TO THE CERVICAL SPINE, THORACIC SPINE, AND LUMBAR SPINE: Upheld

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

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

Decision rationale: The Official Disability Guidelines indicate that shockwave therapy it is not recommended. The available evidence does not support the effectiveness of ultrasound or shockwave for treating low back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. The injured worker was diagnosed with cervical, thoracic and lumbar spine myofascial pain syndrome. The injured worker is noted to have decreased sensation in a C5-6 distribution. Bilateral upper extremity strength was 4/5 and 5/5. The injured worker does have a C4-5 and C5-6 disc protrusion. The injured worker has declined surgery at this time. According to the guidelines shockwave therapy for the cervical, thoracic and lumbar spine is not recommended. Also, the request as submitted failed to provide the frequency at which the therapy would be provided. Therefore, the request is non-certified.

PRESCRIPTION OF FLURBIPROFEN 20% GEL 120 GRAMS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: The injured worker is status post a left laminectomy at L5-S1, diagnosed with cervical, thoracic and lumbar spine myofascial pain syndrome. The physician noted that the injured worker had C4-5 and C5-6 disc protrusions and had declined surgery at this time. The injured worker was seen on 08/27/2013 with complaints of neck pain and lower back pain radiating to the upper and lower extremities. The exam noted decreased cervical range of motion and decreased sensation in a C5-6 distribution. The injured worker had complaints of neck pain rated at a 7/10 and back pain rated at an 8/10. The MTUS Guidelines indicate that for topical analgesics, the efficacy and clinical trials for this treatment modality have been inconsistent. There is little evidence to utilize topical nonsteroidal anti-inflammatories for the treatment of osteoarthritis of the spine, hip or shoulder. It is not recommended as there is no evidence to support use for neuropathic pain. The request as submitted failed to indicate the area of the body the topical cream would be applied to, or the frequency it was to be applied, to determine necessity. Therefore, flurbiprofen 20% gel is not recommended.

PRESCRIPTION OF KETOPROFEN 20% KETAMINE 10% GEL 120 GRAMS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: The injured worker is status post a left laminectomy at L5-S1, diagnosed with cervical, thoracic and lumbar spine myofascial pain syndrome. The physician noted that the injured worker had C4-5 and C5-6 disc protrusions and had declined surgery at this time. The injured worker was seen on 08/27/2013 with complaints of neck pain and lower back pain radiating to the upper and lower extremities. The exam noted decreased cervical range of motion and decreased sensation in a C5-6 distribution. The injured worker had complaints of neck pain rated at a 7/10 and back pain rated at an 8/10. The MTUS Guidelines indicate that for topical analgesics, they are experimental in use with few randomized, controlled trials to determine efficacy or safety. Ketoprofen, which is a nonsteroidal anti-inflammatory agent, is not currently FDA-approved for topical applications. The guidelines indicate that regarding nonsteroidal anti-inflammatory agents, the efficacy in clinical trials for this treatment modality has been inconsistent. Ketamine is noted to be under study and is only recommended for treatment in neuropathic pain in refractory cases in which all primary and secondary treatments have been exhausted. In regard to topical analgesics, it is also noted that any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Ketoprofen is not currently FDA-approved, and ketamine is still under study. Therefore, according to the guidelines, the request for ketoprofen 20%/ketamine 10% gel at 120 gm is non-certified.

PRESCRIPTION OF GABAPENTIN 10%/ CYCLOBENZAPRINE 10% 5 CAPSACIN 0.0375% 30 GRAMS APPLY TO AFFECTED AREA 2-3 TIMES PER DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111-113.

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

Decision rationale: The injured worker is status post a left laminectomy at L5-S1, diagnosed with cervical, thoracic and lumbar spine myofascial pain syndrome. The physician noted that the injured worker had C4-5 and C5-6 disc protrusions and had declined surgery at this time. The injured worker was seen on 08/27/2013 with complaints of neck pain and lower back pain radiating to the upper and lower extremities. The exam noted decreased cervical range of motion and decreased sensation in a C5-6 distribution. The injured worker had complaints of neck pain rated at a 7/10 and back pain rated at an 8/10. The MTUS Guidelines indicate that topical analgesics are largely experimental in use with few randomized, controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended as there is no peer-reviewed literature to supports its use. Cyclobenzaprine is a muscle relaxant, and it is noted that there is no evidence for the use of any other muscle relaxant as a topical product. Capsaicin is recommended only as an option in patients who have not responded to or are intolerant to other

treatments. It was noted that the dose requested was 0.0375%. There have been no studies of a 0.0375% formulation of capsaicin, and there is no indication that this increase over the 0.025% formulation would provide any further efficacy. According to the California Guidelines on topical analgesics, the prescription of gabapentin 10%/cyclobenzaprine 10%/capsaicin 0.0375% at 30 gm is non-certified.