

Case Number:	CM14-0003341		
Date Assigned:	01/31/2014	Date of Injury:	03/20/2010
Decision Date:	06/19/2014	UR Denial Date:	12/23/2013
Priority:	Standard	Application Received:	01/08/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/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 54-year-old female who has filed a claim for cervical degenerative disc disease with radiculopathy associated with an industrial injury date of March 20, 2010. Review of progress notes reports neck pain radiating to the bilateral upper extremities, worse on the right. Findings include tenderness and spasm of the cervical region and positive Spurling test on the right. There is also decreased strength of the entire upper extremity secondary to pain. Patient also has right carpal tunnel syndrome, right de Quervain's tenosynovitis, and right shoulder impingement with corresponding surgical interventions. Cervical MRI, dated February 18, 2013, showed disc protrusions at C5-6 and C6-7 with potential for impingement on the exiting right C6 and left C7 nerves, mild spinal canal stenosis at C5-6, and mild to moderate left C7-T1 foraminal encroachment. The treatments to date has included gabapentin, opioids, muscle relaxants, compound analgesic cream, physical therapy and acupuncture to the right wrist/hand, home exercises, injections to the neck, and cervical trans laminar epidural injection in March 2013. Patient has had right carpal tunnel release, arthroscopic surgery to the right shoulder in June 2012, and right wrist surgery in December 2011. Utilization review from December 23, 2013 denied the request for Baclofen 10mg; compound analgesic cream containing Tramadol, gabapentin, capsaicin, menthol, and camphor; and thermo cool hot and cold contrast therapy with compression. There is modified approval for cervical epidural steroid injection at C7-T1, and for Tylenol #3 for 60 tablets. Reasons for denial were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

TYLENOL NO.3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 78-81.

Decision rationale: As noted on pages 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since August 2013. There is no documentation regarding objective functional benefits derived from this medication, or periodic urine drug screens to monitor proper medication use. The requested quantity is not specified. Previous utilization review determination, dated December 23, 2013, has already certified this request for 60 tablets. Therefore, the request for Tylenol no.3 is not medically necessary.

BACLOFEN 10MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines pages Page(s): 63-66.

Decision rationale: As stated on CA MTUS Chronic Pain Medical Treatment Guidelines pages 63-66, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. They may be effective in reducing pain and muscle tension, and increasing mobility. However, they show no benefit beyond NSAIDs in pain and overall improvement. Patient has been on this medication since at least June 2013. Although findings include cervical spasms, this medication is not recommended for long-term use. Also, the requested quantity is not specified. Therefore, the request for baclofen 10mg was not medically necessary per the guideline recommendations of CA MTUS.

**THERMOCOOL HOT AND COLD CONTRAST THERAPY WITH COMPRESSION:
Upheld**

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and [REDACTED] was used instead. [REDACTED] considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System, the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. In this case, patient has not undergone recent surgery. Also, there is not enough evidence to support the use of this treatment modality. Therefore, the request for Thermacool hot and cold contrast therapy with compression was not medically necessary per the guideline recommendations of [REDACTED].

CERVICAL EPIDURAL STEROID INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Epidural Steroid Inject.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 46.

Decision rationale: As noted on page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injections are recommended in patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Furthermore, repeat blocks should only be offered if at least 50% pain relief with associated reduction of medication use for six to eight weeks was observed following previous injection. There is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Patient had previous right cervical epidural steroid injection on May 06, 2013, resulting in about 60% symptom relief lasting only one week. The previous injection did not produce significant results to support a repeat injection. Also, previous utilization review determination, dated December 23, 2013, already authorized this procedure. Certification of this procedure may lead to duplication of services. Therefore, the request for cervical epidural steroid injection is not medically necessary per the guideline recommendations of CA MTUS.

COMPOUND CREAM: TRAMADOL, GABAPENTIN, CAPSAICIN, MENTHOL, CAMPHOR: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical salicylates

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines page 111 states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Regarding the Capsaicin component, topical Capsaicin is only recommended as an option when there is failure of or intolerance to other treatments; with the 0.025% formulation indicated for osteoarthritis. Regarding the gabapentin component, gabapentin is not recommended for use as a topical analgesic. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. There is no specific discussion regarding topical tramadol and camphor. Patient has been on this medication since December 2013. There is no evidence to support the use of this compounded topical medication. Therefore, the request for compound cream: tramadol, gabapentin, capsaicin, menthol, camphor was not medically necessary per the guideline recommendations of CA MTUS.