

Case Number:	CM14-0131048		
Date Assigned:	08/20/2014	Date of Injury:	07/24/2009
Decision Date:	09/25/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	08/15/2014

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 Physical Medicine and Rehabilitation 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 injured worker is a 56-year-old female who reported an injury on 7/24/2009 due to unspecified mechanism of injury. The injured worker had a history of lower back pain that radiated to the lower extremity, neck pain that radiated to the upper extremities and right shoulder pain associated with tingling and numbness of the right arm. The injured worker had a diagnosis of lower back pain with degenerative disc disease, right piriformis syndrome with impinged sciatic nerve, lumbar spine strain, cervical degenerative disc disease, and right upper extremity pain. The MRI of the cervical spine of unknown date revealed a disc protrusion at C5-6 and C6-7. The past treatments included medications. The objective findings to the cervical spine dated 7/5/2014 revealed tender to palpation over the paracervical muscles, Spurling test was positive on the right side, and facet loading was negative. The sensory examination of the upper extremities revealed decreased sensation to light touch at the C4-5, C5-6, and C8 nerve distribution. Motor examination to the shoulder revealed adduction of 4/5 on the right and 5/5 on the left. Examination of the lumbar spine revealed heel walk and toe walk abnormal on the right side, secondary to pain. Motor examination of the right lower extremity was 4/5 compared with the left, which was 5/5. Sensory examination of the lower extremities revealed decreased sensation to light touch on the right L5 nerve distribution, tenderness to palpation on the posterosuperior iliac spine, the sacroiliac joint and facet joint, and tenderness over the right piriformis muscle. Straight leg raise was positive in the sitting position. The medications included Tizanidine, Celebrex, and a compound analgesic cream that contained tramadol, gabapentin, capsaicin, camphor, ibuprofen 800 mg, and menthol. The treatment plan was to continue to appeal denial of authorization for the cervical epidural steroid injection, and continue medication. Followup 07/24/2014. Request for Authorization dated 08/12/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800mg, #60: 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 Laboratory Testing, NSAIDS Page(s): 70.

Decision rationale: The request for Ibuprofen 800mg, #60 not medically necessary. The California MTUS guidelines indicate that the package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. The documentation was not evident of any lab other than drug screen. The request is not address the frequency. As such, the request is not medically necessary.

Tizanidine 4mg, #30: 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 Tizanidine Page(s): 66.

Decision rationale: The request for Tizanidine 4mg, #30 is not medically necessary. The California MTUS guidelines recommend Tizanidine (Zanaflex) as a non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Guidelines indicate Tizanidine as a second line muscle relaxant. No documentation of efficacy. The request did not address the frequency. The request is not medically necessary.

TGHot cream 120 grams, #1: 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 Topical Analgesics Page(s): 105,111-113.

Decision rationale: The request for TGHot cream 120 grams, #1 is not medically necessary. The CA MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety; also, that they are primarily

recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally 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; however, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended, therefore, is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The CA MTUS states that Gabapentin is not recommended. There is no peer-reviewed literature to support use. The request did not address frequency. As such, the request is not medically necessary.