

Case Number:	CM14-0169225		
Date Assigned:	10/17/2014	Date of Injury:	04/21/2010
Decision Date:	11/19/2014	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/14/2014

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 Emergency 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:

Patient with reported date of injury on 4/21/2010. No mechanism of injury was provided for review. Patient has a diagnosis of multilevel disk herniation of lumbar spine with facet arthropathy, probable cervical radiculopathy and cervical stenosis of C5-6. Patient is post L elbow surgery, L shoulder arthroscopic surgery and R carpal tunnel release. Medical reports reviewed. Last report available until 9/9/14. Patient complains of worsening neck pain. Pain radiates down L arm with numbness and tingling. Also complains of shoulder and low back pain. Has "functional improvement" and "pain relief" with medications. Objective exam reveals cervical spine tenderness from posterior cervical area to bilateral trapezius. L arm with noted decreased sensation to volar aspect of L thumb, index and middle finger. Lumbar exam revealed tenderness and limited range of motion. Positive straight leg raise on L side. No imaging or electrodiagnostic reports were provided for review. No medication list was provided. Only noted medications are those that have been requested during this review. Patient has had reportedly prior cervical epidural injections that provided "improvement" in pain. No other prior treatment modalities were provided in the progress notes. Independent Medical Review is for Tylenol with codeine #60 with 2 refills (#180), Cervical Epidural Steroid injection (repeat) and LF520 (Lidocaine 5%/Flurbiprofen 20%) 120 grams with 2 refills. Prior UR on 10/2/14 recommended modification of Tylenol #3 to #60 with no refills and non-certification of cervical epidural and LF520. It approved an 60 mg injection of Toradol intramuscular.

IMR ISSUES, DECISIONS AND RATIONALES

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

Refill Tylenol with Codeine #3, #60 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78.

Decision rationale: Tylenol #3 is acetaminophen and codeine, an opioid. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation does not meet the appropriate documentation of criteria. There is no noted objective improvement in function with medications or improvement in pain. The providers have apparently never documentation pain as per visual analogue scale or any accepted measuring tool. There are vague documentation of "functional improvement" and "helps with" but this is contradicted by the complaint of worsening pain a request for epidural injection. There is no documentation of proper assessment for abuse or a pain contract. The number of tablets and refills requested is excessive, not appropriate and does not meet MTUS Chronic pain guidelines concerning appropriate monitoring of patients on Chronic opioid therapy. Documentation does not support continued use of opioids. Tylenol #3 is not medically necessary.

Repeat Cervical Epidural under the care of [REDACTED]: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection(ESI) Page(s): 45.

Decision rationale: As per MTUS Chronic Pain guidelines, Epidural Steroid Injection (ESI) may be recommended as an option under specific criteria. Its primary purpose is to reduce pain and inflammation to avoid surgery or to allow increased active therapy. Basic criteria for approval: 1) Radiculopathy is documented. Report claims that EMG/NCV supports claims of radiculopathy but those reports were not provided for review. Report reveals some decrease sensation that could be consistent with radiculopathy. Presumptively meets criteria. 2) Initially unresponsive to conservative therapy. Providers have failed to document the existing plan and prior treatment. There is documentation of failure of physical therapy but no documentation of concurrent medication therapy and other conservative modalities. Fails criteria. 3) Treatment is to decrease pain, to allow patient to improve function and prevent surgery. There is no documentation of a plan for ESI to increase tolerance for physical therapy or to avoid surgery, it only notes plan is to decrease pain. Fails criteria. 4) Documentation of improvement in objectively documented pain after prior ESI of at least 50% in pain lasting 6-8 weeks. Fails criteria. There is report of a prior ESI but and that it "helped a lot" but there is no documentation of any objective improvement in pain or function or for how long. Patient fails multiple basic criteria for recommendation for ESI therefore Epidural Steroid Injection is not medically necessary.

LF520 (Lidocaine 5%,Flurbiprofen 20 %) 120 Grams 2 Refills: 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: As per MTUS guidelines "Any compound product that contains a drug or drug class that is no recommended is not recommended." 1) Flurbiprofen: Shown to be superior to placebo. It should not be used long term. It may be useful. Patient appears to be on this medications chronically. While there is subjective report of improvement, provider has not appropriately documented close monitoring for potential side effects of chronic topical NSAID use or appropriate monitoring or pain such a pain scale. Flurbiprofen is not FDA approved for topical application. There is no justification by the provider as to why the patient requires a non-FDA approved compounded NSAID when there are multiple other approved products including over the counter medications on the market. Flurbiprofen is not medically necessary. 2) Lidocaine: Topical lidocaine is recommended for post-herpetic neuralgia only although it may be considered as off-label use as a second line agent for peripheral neuropathic pain. It may be considered for peripheral neuropathic pain only after a trial of 1st line agent. There is no documentation of an attempt of trial with a 1st line agent and there is no documentation on where the cream is to be used. It is therefore not recommended. Both components of this compounded medication is not medically necessary therefore the entire compounded product is not medically necessary.