

Case Number:	CM14-0029516		
Date Assigned:	06/16/2014	Date of Injury:	02/29/2012
Decision Date:	08/04/2014	UR Denial Date:	03/06/2014
Priority:	Standard	Application Received:	03/07/2014

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 has a subspecialty in Interventional Spine 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 45-year-old male with a date of injury of 02/29/2012. The listed diagnoses per [REDACTED] are: 1. Left shoulder superior labral anterior posterior lesion and tear of the posterior labrum. 2. Disk protrusion at C3-C4, C4-C5 and C5-C6 levels with moderate spinal stenosis and left neuroforaminal stenosis. 3. Left upper extremity radiculopathy. 4. Neuropathic of the left upper extremity. 5. Insomnia. 6. Status post left arthroscopy on 05/23/2013 with 75% relief of symptoms. 7. Moderate right greater than left carpal tunnel syndrome with mild chronic C5 to C6 radiculopathy. 8. Status post left carpal tunnel release in 2005. 9. Status post anterior cervical discectomy and fusion at C3 to C6 on 10/18/2013. According to progress report 02/04/2014 by [REDACTED], the patient complains of intermittent neck pain with occasion radiating to the left upper extremity. He notes some numbness around the area of his beard. He also complains of intermittent left shoulder pain with radiation to the trapezius muscle. He also further complains of frequent low back pain rated 2-3/10. The patient is status post anterior cervical discectomy fusion at C3 to C4, C4 to C5 and C5 to C6 levels on 10/18/2013. Request for authorization from 02/04/2014 requests MRI scan of the lumbosacral spine and a topical gel which includes flurbiprofen, ketoprofen, ketamine, gabapentin, cyclobenzaprine, and capsaicin. Utilization review denied the request on 03/06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI LUMBAR: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ODG-TWC guidelines (http://www.odg-twc.com/odgtwc/low_back.htm#Protocols)-Indications For Imaging -- Magnetic Resonance Imaging (MRI).

Decision rationale: For special diagnostics, ACOEM Guidelines page 303 states unequivocal objective findings that identify specific nerve compromise on the neurological examination is sufficient evidence to warrant imaging in patients who do not respond well to treatment and who would consider surgery as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. This patient presents with neck, low back and left shoulder pain. On 02/14/2014, treater reported patient has increasing symptoms in the low back over the last two years with increasing pain, spasms and radiation to the lower extremities. The treater states the patient had an MRI of the lumbar a few years ago. The results were not provided. In this case, the treater would like an updated MRI for increased symptoms over the past 2 years. However, there are no new injuries, no significant changes in examination, no bowel/bladder symptoms, no new location of symptoms requiring additional investigation. The request for MRI (Lumbar) is not medically necessary.

2. TOPICAL MED FLURBIPROFEN, KETOPROFEN, KETAMINE AND GABAPENTIN CYCLOBENZAPRINE CAPSAICIN GEL: 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): 111.

Decision rationale: The MTUS Guidelines p 111 has the following regarding topical creams, topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety. MTUS further states, any compounded product that contains at least one (or drug class) that is not recommended is not recommended. The MTUS Guidelines allows capsaicin for chronic pain condition such as fibromyalgia, osteoarthritis, and nonspecific low back pain. However, MTUS Guidelines considers doses that are higher than 0.025% to be experimental particularly at high doses. The requested cream contains 0.035% of capsaicin is not supported by MTUS. Therefore, the entire compound ointment is not recommended. This patient is status post anterior cervical discectomy fusion at C3 to C4, C4 to C5 and C5 to C6 on 10/18/2013. It was noted the patient is progressing well and has decrease in pain, but his mobility is still quite restricted. The treater is requesting a refill of topical medication which includes flurbiprofen 20% gel 120 g, ketoprofen 20%/ketamine 10% gel 120 g, gabapentin 10%/cyclobenzaprine 10%/capsaicin 0.035% gel 120 g. The request for Topical Med

Flurbiprofen, Ketoprofen, Ketamine And Gabapentin Cyclobenzaprine Capsaicin Gel is not medically necessary.