

Case Number:	CM14-0030420		
Date Assigned:	06/20/2014	Date of Injury:	01/23/2007
Decision Date:	07/17/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/10/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 56-year-old male with a 1/23/07 date of injury. At the time (1/14/14) of the request for authorization for unknown prescription of Capsaicin, Flurbiprofen cream; 1 lumbar epidural steroid injection; and 1 TENS/EMS unit, there is documentation of subjective (low back pain and neck pain) and objective (continued S1 radicular pain and spasm, tenderness to palpation over the midline to the right and over the right-sided facet joints, range of motion is decreased and painful, decreased sensory to pinprick and light touch lateral aspect and bilateral feet and dorsal forefoot) findings, imaging (MRI lumbar spine (5/31/13) report revealed at L5-S1 diffuse disc herniation which causes bilateral neural foraminal stenosis and spinal canal stenosis), current diagnoses (status post hardware removal 12/15/12, status post lumbar fusion, lumbar spine degenerative disc disease, cervical spine degenerative disc disease, lumbar radiculopathy, and severe L5 radiculopathy), and treatment to date (home exercise program, medication including ongoing use of Capsaicin and Flurbiprofen cream, and TENS/EMS unit). Regarding unknown prescription of Capsaicin, Flurbiprofen cream, there is no documentation of the percentage formulation requested and that the patient has not responded or is intolerant to other treatments; functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with use of Capsaicin and Flurbiprofen cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown prescription of Capsaicin, Flurbiprofen cream: 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; Capsaicin, Topical Page(s): 111-113, 28-29.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Specifically regarding Capsaicin, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that patient has not responded or is intolerant to other treatments, as criteria necessary to support the medical necessity of topical capsaicin in a 0.025% formulation. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies that there have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of status post hardware removal 12/15/12, status post lumbar fusion, lumbar spine degenerative disc disease, cervical spine degenerative disc disease, lumbar radiculopathy, and severe L5 radiculopathy. However, there is no documentation of the percentage formulation requested and that the patient has not responded or is intolerant to other treatments. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with use of Capsaicin and Flurbiprofen cream. Therefore, based on guidelines and a review of the evidence, the request for unknown prescription of Capsaicin, Flurbiprofen cream is not medically necessary.

1 Lumbar epidural steroid injection: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs).

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of subjective (pain,

numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, failure of conservative treatment (activity modification, medications, and physical modalities), and no more than two nerve root levels injected one session; as criteria necessary to support the medical necessity of lumbar transforaminal epidural steroid injection using fluoroscopy. Within the medical information available for review, there is documentation of a diagnosis of status post hardware removal 12/15/12, status post lumbar fusion, lumbar spine degenerative disc disease, cervical spine degenerative disc disease, lumbar radiculopathy, and severe L5 radiculopathy. In addition, there is documentation of subjective (pain) and objective (sensory changes) radicular findings in the requested nerve root distribution, imaging (MRI) findings (moderate or greater neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities). Therefore, based on guidelines and a review of the evidence, the request for 1 lumbar epidural steroid injection is medically necessary.

1 TENS/EMS unit: 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 Transcutaneous electrical nerve stimulation (TENS); Neuromuscular Electrical Stimulation Page(s): 113-117; 121.

Decision rationale: Regarding TENS, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a statement identifying that the TENS unit will be used as an adjunct to a program of evidence-based functional restoration, and a treatment plan including the specific short- and long-term goals of treatment with the TENS, as criteria necessary to support the medical necessity of a month trial of a TENS unit. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of how often the unit was used, outcomes in terms of pain relief and function, and other ongoing pain treatment during the trial period (including medication use), as criteria necessary to support the medical necessity of continued TENS unit. Regarding EMS, MTUS Chronic Pain Medical Treatment Guidelines states that neuromuscular electrical stimulation (NMES) is not recommended. In addition, MTUS Chronic Pain Medical Treatment Guidelines states that NMES is primarily used as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. Therefore, based on guidelines and a review of the evidence, the request for 1 TENS/EMS unit is not medically necessary.