

<b>Case Number:</b>	CM14-0037128		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	09/25/2013
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	03/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2014

### 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 Pain Medicine and is licensed to practice in Texas. 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 61 year old male who had a work related injury on 09/25/2013 while moving furniture. The injured worker's pain has been intermittent since then, rated as 3-4/10 with radiation to the right lower extremity to the buttocks, lateral thigh and bilateral leg with numbness. His symptoms have improved after physical therapy and now mostly in the lateral leg only and less in the lower back. Lifting, bending, and walking all make his pain worse, while rest improves it. The injured worker is on restricted duty. It was noted on the 04/01/14 progress note that the injured worker was not tolerating oral medications well, especially while trying to work, perform ADLs and also had some GI irritation. Physical examination on 04/01/14 notes that sensory exam is intact to light touch globally. Motor strength is rated as 5/5. Reflexes are 2/2 in lower extremities. No impairment of tandem walking, heel or toe walking. There is moderate tenderness to palpation along the lumbosacral spine. Range of motion was limited due to guarding and pain. Straight leg raising is positive on the right and slump test is positive on the right. (There is no documented degree of straight leg raising, or if the pain radiates below his knee.) MRI of the lumbar spine dated 01/07/14 revealed at L2-3 there is disc desiccation without narrowing. A 2 mm annular disc bulge mildly encroaches on the thecal sac without nerve root improvement. L3-4 mild disc desiccation without narrowing is present. A 1-2 mm annular disc bulge mildly encroaches on the thecal sac without nerve root encroachment. L4-5 mild disc desiccation without narrowing is present. A 4 mm disc protrusion is present centrally and eccentric toward the right extending into the proximal aspect of the right L4 nerve root foramen. There appears to be abutment of the descending right L5 nerve root and likely encroaching on the exiting right L4 nerve root. Clinical correlation for symptomatology in these nerve root distributions is recommended. L5-S1 minimal disc desiccation without narrowing is present. No disc protrusion or bulge is identified. Electrodiagnostic studies (EMG/NCV) on 03/03/14 notes

bilateral lower extremities are without electrodiagnostic evidence for a peripheral neuropathy. Electromyography of the bilateral lower extremities and lumbar paraspinal muscles is without active or chronic denervation potentials to suggest a lumbosacral radiculopathy at this time.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Epidural steroid injection right L4-L5 with sedation: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Epidural steroid injections (ESIs).

**Decision rationale:** The request for epidural steroid injection right L4-L5 is not medically necessary. The clinical documentation submitted for review does not support the request. Straight leg raising is positive on the right and slump test is positive on the right. (There is no documented degree of straight leg raising, or if the pain radiate below his knee.) No motor weakness, no sensory deficit. Electromyography of the bilateral lower extremities and lumbar paraspinal muscles is without active or chronic denervation potentials to suggest a lumbosacral radiculopathy. MRI report, a 4 mm disc protrusion is present centrally and eccentric toward the right extending into the proximal aspect of the right L4 nerve root foramen L4/5 level appears to abut the descending right L5 nerve root and likely encroaching on the exiting right L4 nerve root. Clinical correlation for symptomatology in these nerve root distributions is recommended. Therefore medical necessity has not been established.

**Flurbiprofen compound 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 Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, compound drug.

**Decision rationale:** The request for Fluriprofen compound cream is not medically necessary. The current evidence based guidelines do not support the request. California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: Lidocaine which have not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.

**Tramadol compound 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 Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain compound drug.

**Decision rationale:** The request for Tramadol compound cream is not medically necessary. The current evidence based guidelines do not support the request. California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: Tramadol which have not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.