

<b>Case Number:</b>	CM14-0068194		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	10/03/2012
<b>Decision Date:</b>	08/26/2014	<b>UR Denial Date:</b>	04/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2014

### 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 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:

The injured worker is a 45 year old male who had a work related injury on 10/03/12. It was a slip and fall injury and he injured his neck and lower back. Treatment has consisted of several lumbar epidural steroid injections, cervical epidural steroid injections with 4-5 days of relief. Pain scale before the cervical injection was 4-5 on a scale of 0-10. After the injection it reduced to it a 3 on a scale of 0-10. He also has had chiropractic treatment, medication including Tramadol ER for pain, Cyclobenzaprine for spasm and topical ointments for pain. His pain is aggravated by prolonged sitting, prolonged standing, prolonged walking, repetitive bending, repetitive neck bending, repetitive stooping, repetitive kneeling, repetitive squatting, repetitive overhead reaching, repetitive twisting, repetitive lifting, carrying and repetitive hand and arm movements. His pain is reduced with rest and cold. The most recent document submitted for review dated 03/26/14 MRI of the cervical spine dated 10/29/12 showed C5-6 1mm disc protrusion. The physical examination ambulation is normal. The shoulder examination reveals non-specific tenderness in the right shoulder. Palpation indicates tenderness at the supraspinatus and infraspinatus and bicipital groove on the right. Tinel's sign is negative on both wrists. Phalen's test is positive on the right and negative on the left. Reflexes for biceps and triceps are normal bilaterally. Brachial radialis are normal bilaterally. There is no loss of sensation or pain in the anterolateral shoulder and arm on the right corresponding to the C5 dermatome. There is no loss of sensibility, abnormal sensation, or pain in the anterolateral shoulder on the left corresponding to C5 dermatome. At the C6-7 and C7-T1 palpation reveals moderate paraspinal spasm, tenderness bilaterally. At levels C6-7 and C7-T1 palpation reveals slight spinal tenderness bilaterally. Foraminal compression test, distraction with relief of pain, extension compression test, flexion compression test, Jackson's compression test, and shoulder depressor test are positive on both sides. Valsalva test is negative on both sides. The flexion of the cervical spine is

40 degrees and the extension is 40 degrees. Rotation to the right is 60 degrees to the left is 65 degrees. Lateral bending to the right is 35 degrees and the left is 40 degrees. The lumbar spine exam Kemp's test, facet is positive on both sides. Heel walk and toe walk are negative on both sides. Reflexes are normal bilaterally in the lower extremities. Sensation is intact in lower extremities. At the L4-5 and L5-S1 palpation reveals paraspinal tenderness, muscle guarding, and spasms bilaterally. At levels L4-5 and L5-S1 palpation reveals spinal tenderness bilaterally. Straight leg raising at 90 degrees reproduced a pulling sensation in the lower back. Flexion of the lumbar spine is 50 degrees. Lumbar extension is 15 degrees. Lateral bending to the right and left is 20 degrees. The diagnoses include cervicalgia, displacement of cervical intervertebral disc without myelopathy, cervical radiculopathy, lumbago, displacement of lumbar intervertebral disc without myelopathy, lumbar facet joint syndrome/hypertrophy, myalgia, and neuroforaminal narrowing at L4-5. Prior utilization review on 04/14/14 was non-certified. Psychological evaluation was recommended to determine if the injured worker is sufficiently stable and secure emotionally to undergo a C5-6 cervical epidural steroid injection.

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

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

**Psych eval:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations Page(s): 100-101 of 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office visits.

**Decision rationale:** The request for Psych evaluation is not medically necessary. The injured worker had undergone the same procedure less than 6 months ago without documented problem. There is no clinical documentation submitted for review that supports the request. Therefore medical necessity has not been established.

**CS Exercise kit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Neck and Upper back (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck chapter, Traction.

**Decision rationale:** The request for CS Traction Unit is not medically necessary. Recommend home cervical patient controlled traction (using a seated over-the-door device or a supine device, which may be preferred due to greater forces), for patients with radicular symptoms, in conjunction with a home exercise program. The clinical documentation submitted for review

shows no evidence of cervical radicular symptoms. As such, medical necessity has not been established.

**CS Traction Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 174 of 193.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back chapter, Exercise.

**Decision rationale:** The request for CS Exercise kit is not medically necessary. The clinical documentation submitted for review does not describe what this is, if it is self-taught, if it will require training. Therefore medical necessity has not been established.

**Keto-Cyclo-Lido Cream:** 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, compound drug(s).

**Decision rationale:** The request for Keto-Cyclo-Lido Cream is not medically necessary. California Medical Treatment Utilization Schedule, the Official Disability Guidelines and United States Food and Drug Administration (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 Ketoprofen which has 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.

**Flurbiprofen-Capsaicin-Menthol-Camphor:** 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, compound drug(s).

**Decision rationale:** The request for Flurbiprofen-Capsaicin-Menthol-Camphor is not medically necessary. California Medical Treatment Utilization Schedule, the Official Disability Guidelines

and United States Food and Drug Administration (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 Flurbiprofen which has 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.