

Case Number:	CM14-0081513		
Date Assigned:	07/18/2014	Date of Injury:	03/15/1996
Decision Date:	08/26/2014	UR Denial Date:	05/08/2014
Priority:	Standard	Application Received:	06/02/2014

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 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:

This is a patient with a date of injury of 3/15/96. A utilization review determination dated 5/8/14 recommends non-certification of topical medication, pain management psychologist, and EMG/NCV bilateral upper and lower extremities. 4/24/14 medical report identifies severe pain in the back, neck, and arms. Pain is 5-9/10. On exam, there is tenderness in the upper to lower back, SI, and greater trochanteric bursa area. Back ROM is limited with pain. Recommendations included topical medication, medications, CBC and CMP, PT, pain management psychologist, EMG/NCS, lumbosacral corset, and weight loss.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 10%, Lidocaine 5%, Gabapentin 10% in topical Lipoderm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 111-113 of 127 Page(s): 111-113 OF 127.

Decision rationale: Regarding the request for Ketoprofen 10%, Lidocaine 5%, Gabapentin 10% in topical Lipoderm, California MTUS notes that topical NSAIDs are indicated for

"Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical ketoprofen is "not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis." Topical lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." Additionally, it is supported only as a dermal patch. Gabapentin is not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the currently requested Ketoprofen 10%, Lidocaine 5%, Gabapentin 10% in topical Lipoderm is not medically necessary.

Pain Management Psychologist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 100-102 of 127 Page(s): 100-102 OF 127.

Decision rationale: Regarding the request for Pain Management Psychologist, Chronic Pain Medical Treatment Guidelines state that psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected using pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury, or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. Within the documentation available for review, there is no documentation of any psychological symptoms and/or findings and a clear rationale for a pain management psychologist in the absence of any signification psychological issues. In the absence of such documentation, the currently requested Pain Management Psychologist is not medically necessary.

EMG-NCV Bilateral Upper and Low Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-182, 303.

Decision rationale: Regarding the request for EMG-NCV Bilateral Upper and Low Extremities, the CA MTUS and ACOEM support electrodiagnostic studies to help identify subtle focal neurologic dysfunction after failure of conservative management. Within the documentation

available for review, there are no recent physical examination findings identifying any subtle focal neurologic deficits in either the upper or lower extremities for which the use of electrodiagnostic testing would be indicated. In the absence of such documentation, the currently requested EMG-NCV Bilateral Upper and Low Extremities is not medically necessary.