

Case Number:	CM14-0089312		
Date Assigned:	08/08/2014	Date of Injury:	03/20/2014
Decision Date:	10/01/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/13/2014

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 Physical Medicine and Rehabilitation 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 51 year old female who sustained an injury on 03/20/14 when she experienced popping sensation in the low back followed by sharp pain performing the normal activities of her occupation. No documentation regarding conservative treatment was noted through April of 2014. The injured worker was placed on anti-inflammatories, analgesics for pain as well as omeprazole and a compounded medication. The clinical report from 06/17/14 noted that the injured worker had persistent complaints of low back pain that was severe 8-9/10 in intensity radiating to the lower extremities. The injured worker did report up to 80% relief with the use of anti-inflammatories, topical analgesics and Tylenol 3. The injured worker did undergo selective nerve root blocks on 06/03/14. The response was not specifically noted. On physical examination there were spasms and tenderness to palpation of the lumbar spine. Straight leg raising signs were reported as positive to the left. There was noted weakness of the quadriceps, extensor hallucis longus and tibialis anterior. Magnetic resonance imaging (MRI) studies did note large disc protrusions at L2-3 and L3-4 with chronic changes at L4-5 and L5-S1. There were considerations being made for further laminotomy, foraminotomy decompression procedures. There was a recommendation for this procedure noted in the clinical report. The requested Computed Tomography (CT) of the lumbar spine, Electromyography (EMG) as well as topical medications and urine drug screen testing was all denied by utilization review on 05/28/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computed Tomography (CT) Scan of the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: In regards to the request for Computed Tomography (CT) Scan of the Lumbar Spine, the prior magnetic resonance imaging (MRI) studies did note disc pathology primarily at L2-3 and L3-4 for which the injured worker did undergo selective nerve root blocks at these levels. At this point in time, there are no indications of any other conditions that would support CT studies of the lumbar spine given the MRI findings. Although the injured worker has been recommended for surgical intervention, there is no indication that this has been approved to date. There is no clear indication for CT scan of the lumbar spine to plan surgical intervention. Given the lack of any other indication for the use of CT studies for the lumbar spine; the request for Computed Tomography (CT) Scan of the Lumbar Spine is not medically necessary.

Electromyography (EMG): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for Electromyography (EMG) is not medically necessary. From the clinical documentation submitted for review, there is no clear indication of any equivocal signs or symptoms of radiculopathy that would require this test. At this point in time it is unclear how electrodiagnostic studies would contribute further clinical information that would help guide a course of treatment in this case. The injured worker has already been recommended for surgical intervention. Therefore, this request is not medically necessary at this time.

Nerve Conduction Velocity (NCV): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for Nerve Conduction Velocity (NCV) is not medically necessary. From the clinical documentation submitted for review, there is no clear indication of any equivocal signs or symptoms of radiculopathy that would require this test. At this point in time it is unclear how electrodiagnostic studies would contribute further clinical information that would help guide a course of treatment in this case. The injured worker has already been recommended for surgical intervention. Therefore, the request is not medically necessary at this time.

Flurbiprofen 20% cream 120g to affect area 2-3 times daily: 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): 111-113.

Decision rationale: In regards to the use of topical compounded medications that include Flurbiprofen, the request is not medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Flurbiprofen which is not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, the request is not medically necessary.

Ketoprofen 20% 120g, Ketamine 10% cream 120g, apply to affected area 2-3 times daily: 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): 111-113.

Decision rationale: In regards to the use of topical compounded medications that include Ketoprofen and Ketamine, the request is not medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Ketoprofen and Ketamine which are not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, the request is not medically necessary.

Gabapentin 10%, Cyclobenzaprine 10%, Capsaicin 0.0375% 120g, apply to affected area 2-3 times daily: 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): 111-113.

Decision rationale: In regards to the use of topical compounded medications that include Gabapentin, Cyclobenzaprine, and Capsaicin, the request is not medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Gabapentin and Cyclobenzaprine which are not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, the request is not medically necessary.

Urine drug test: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Pain Chapter, Urine Drug Testing

Decision rationale: In review of the clinical documentation submitted, the request for a urine drug screen testing is not medically necessary. The clinical documentation provided for review did not identify any current scheduled medications being prescribed to the injured worker. There are no other risk factors noted in the clinical records to support concerns for aberrant medication abuse or diversion. Therefore, the proposed urine drug screen testing for this injured worker is not medically necessary.