

Case Number:	CM14-0092031		
Date Assigned:	08/08/2014	Date of Injury:	06/09/2013
Decision Date:	09/23/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	06/16/2014

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 Family Medicine and Addiction Medicine and is licensed to practice in Ohio. 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:

Patient is a 67-year-old female who has submitted a claim for displacement of cervical intervertebral disc without my neuropathy and back ache, associated with an industrial injury the date of 6/9/2013. Medical records from the 2013 to 2014 were reviewed. Patient complained of neck pain, rated 8/10 in severity, radiating to the thoracic and lumbar spine. She likewise complained of low back pain, rated 8 to 9/10 in severity, radiating to the left lower extremity, associated with numbness. She likewise reported of increasing muscle spasms in the left lower extremity. Physical examination of the cervical spine revealed diffuse tenderness, limited range of motion, and positive cervical compression test bilaterally. Examination of the lumbar spine showed muscle spasm, sciatic notch tenderness, positive straight leg raise test and positive tension test bilaterally. MRI of the lumbar spine, dated 9/6/2013, showed disc desiccation, reduced intervertebral disc height, multi-level diffuse disk protrusion and narrowing of the foramina stenosis resulting in encroachment of the right L4, and bilateral L5 exiting nerve roots. Treatment to date has included physical therapy, acupuncture, home exercise program, and medications such as ibuprofen (since 2013), Soma (since 2013), and topical creams. Utilization review from 6/12/2014 denied the requests for Gabapentin Compound (Gabapentin 10% Cyclobenzaprine 10%, Capsaicin 0.0375% 120gm), Ketamine Compound (Ketoprofen 20, Ketamine 10% cream 120gm), and Flurbiprofen Compound (Ketoprofen 20% cream 120gm) due to lack of published studies concerning its efficacy and safety; denied Acupuncture treatment 2x4 for the cervical spine and lumbar spine because there was no documentation of quantified functional improvement from previous sessions; denied Physical Therapy 2-3x4-8 for the cervical spine and lumbar because there was no documentation of functional improvement from previous visits; denied Motrin 800mg #90 because of the abuse was not recommended; denied Soma 350mg #60 because [REDACTED] was not recommended and there was no documentation of

acute exacerbation of chronic pain; denied X-Force stimulator/tens, 30 day trial because the guideline did not address TENS/TEJS unit; denied Solar Care FIR Heating System because there was no documentation that patient had failed under heat therapies; and denied Kronos Lumbar Pneumatic Brace because it was not guideline recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin Compound (Gabapentin 10% Cyclobenzaprine 10%, Capsaicin 0.0375% 120gm): 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 Capsaicin; Topical Analgesics Page(s): 28-29, 111-113.

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. CA MTUS does not support the use of opioid medications and gabapentin in a topical formulation. Cyclobenzaprine is not recommended for use as a topical analgesic. CA MTUS Chronic Pain Medical Treatment Guidelines identifies on page 28 that topical Capsaicin is only recommended as an option if there was failure to respond or intolerance to other treatments. The guideline states there is no current indication that an increase over a 0.025% formulation of capsaicin would provide any further efficacy. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains capsaicin 0.0375%, gabapentin and cyclobenzaprine that are not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. Therefore, the request for Gabapentin Compound (Gabapentin 10% Cyclobenzaprine 10%, Capsaicin 0.0375% 120gm) is not medically necessary.

Ketamine Compound (Ketoprofen 20, Ketamine 10% cream 120gm): 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): 111-113.

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Ketoprofen is not recommended for topical use as there is a high incidence of photo contact dermatitis. Ketamine is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. In this case, topical cream is prescribed as adjuvant therapy to oral

medications. However, the prescribed medication contains Ketoprofen, which is not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. There is likewise no documentation of failure of first-line therapy to warrant ketamine cream. Therefore, the request for Ketamine Compound (Ketoprofen 20, Ketamine 10% cream 120gm is not medically necessary.

Flurbiprofen Compound (Ketoprofen 20% cream 120gm): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Ketoprofen is not recommended for topical use as there is a high incidence of photo contact dermatitis. In addition, there is little to no research as for the use of Flurbiprofen in compounded products. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains Flurbiprofen and Ketoprofen, which are not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. Therefore, the request for Flurbiprofen Compound (Ketoprofen 20% cream 120gm) is not medically necessary.

Acupuncture treatment 2x4 for the cervical spine and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: CA MTUS Acupuncture Medical Treatment Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture treatments may be extended if functional improvement is documented. The frequency and duration to produce functional improvement is 3 - 6 treatments, frequency of 1 - 3 times per week, and duration of 1 - 2 months. It may be extended if functional improvement is documented. In this case, patient has received acupuncture treatment in the past; however, the exact number of visits is not documented in the medical records submitted. There was no documentation stating the pain reduction, functional improvement or decreased medication-usage associated with acupuncture. Therefore, the request for Acupuncture treatment 2x4 for the cervical spine and lumbar spine is not medically necessary.

Physical Therapy 2-3x4-8 for the cervical spine and lumbar: 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 Physical Medicine Page(s): 98-99.

Decision rationale: As stated on pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. In this case, patient initially attended a course of physical therapy. However, the patient's response to treatment and total number of sessions attended were not discussed. There was no objective evidence of overall pain improvement and functional gains derived from the treatment. Moreover, there were no recent reports of acute exacerbation or progression of symptoms that would warrant additional course of treatment. The medical necessity has not been established. Therefore, the request for Physical Therapy 2-3x4-8 for the cervical spine and lumbar is not medically necessary.

Motrin 800mg #90: 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 NSAIDs Page(s): 46.

Decision rationale: As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, patient has been on Motrin since 2013. However, there was no documentation concerning pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. Therefore, the request for Motrin 800mg #90 is not medically necessary.

Soma 350mg #60: 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 Carisoprodol (Soma) Page(s): 29.

Decision rationale: As stated on page 29 of CA MTUS Chronic Pain Medical Treatment Guidelines, Carisoprodol (Soma) is a centrally acting skeletal muscle relaxant that is not indicated for long-term use. Carisoprodol abuse has been noted in order to augment or alter effects of other drugs such as hydrocodone, tramadol, benzodiazepine and codeine. In this case, patient has been on Carisoprodol since 2013. However, there is no documentation concerning

pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. Therefore, the request for Soma 350mg #60 is not medically necessary.

X-Force stimulator/tens, 30 day trial: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, TENS, chronic pain (transcutaneous electrical nerve stimulation) pages Page(s): 114-116.

Decision rationale: The X Force stim is noted to be a TENS unit as well as a transcutaneous electrical joint stimulation unit. As stated on pages 114-116 of the California MTUS Chronic Pain Medical Treatment Guidelines, TENS units are not recommended as the primary treatment modality but a one-month trial may be considered if used as an adjunct to a program of evidence-based functional restoration given that conservative treatment methods have failed and that a specific treatment plan with short and long term goals has been established. The California MTUS, The Official Disability Guidelines, and peer-reviewed literature do not address transcutaneous electrical joint stimulation. In this case, there was no documented rationale for X-force stimulator unit. There was no discussion regarding the necessity for a combination electrotherapy unit. Body part to be treated was likewise not specified. There was no evidence that this modality will be used in conjunction with an exercise program, as recommended by the guidelines. Therefore, the request for X-Force stimulator/tens, 30 day trial is not medically necessary.

Solar Care FIR Heating System: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Infrared Therapy (IR).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Infrared therapy.

Decision rationale: CA MTUS does not specifically address infrared therapy (IR). Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that infrared therapy is not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute low back pain but only as an adjunct to a program of evidence-based conservative care. In this case, it was unclear if there was ongoing exercise program to be used in conjunction to infrared therapy. Solar Care heating system is not recommended as a solitary treatment modality. Furthermore, the duration of intended use, body part to be treated, and whether the device is for

rental or purchase were not specified. Therefore, the request for Solar Care FIR Heating System is not medically necessary.

Kronos Lumbar Pneumatic Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Back brace, post-operative (fusion).

Decision rationale: As stated on page 301 of the CA MTUS ACOEM, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG only recommends back brace as an option for compression fractures. There is no scientific information on the benefit of bracing for clinical outcomes following instrumented lumbar fusion. There may be special circumstances (multilevel cervical fusion, thoracolumbar unstable fusion, non-instrumented fusion, mid-lumbar fractures) in which some external immobilization might be desirable. In this case, patient complained of chronic back pain since the industrial injury date of June 2013, which is beyond guideline recommendation for use of back brace. Moreover, there was no documented indication for this special type of brace. The medical necessity cannot be established due to insufficient information. Therefore, the request for purchase of Kronos lumbar pneumatic brace is not medically necessary.