

Case Number:	CM14-0197428		
Date Assigned:	12/05/2014	Date of Injury:	08/18/2010
Decision Date:	01/22/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	11/24/2014

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 Rehab, has a subspecialty in Interventional Spine 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 47 year-old injured worker who sustained an injury to left knee and back on 08/18/2010. Since the injury she has had physical therapy which provided little to no relief, massage therapy which increased the pain, chiropractic treatment with no relief and increased pain, and a home exercise program. She had a left knee arthroscopy in 2010 and a repeat of the left knee arthroscopy in 2011. According to the utilization Review (UR) letter of 11/10/2014, an x-ray of the lumbar spine dated 2011 documented no hypermobile segments. The IW also underwent shoulder surgery x2 in 2009. The current diagnosis is lumbosacral spondylosis without myelopathy. On the 11/13/2014 physician visit, her subjective complaints were persistent left low back pain that was a 4-6 on a scale of 10. Objective findings were tightness in the left lumbar area with pain and spasm, radiation of pain to the greater trochanter. The treatment plan includes referral to physical therapy, medial branch blocks bilaterally at L3-L4, and oral and topical medications for chronic low back pain. The IW is taking Norco and Nonsteroidal anti-inflammatories for pain control. A request for authorization was made 11/04/2014 for compound cream Diclofenac 5%, Gabapentin 6%, Baclofen 2%, cyclobenzaprine 2%, Bupivacaine 1%, lidocaine 5% and Fluticasone 1% apply 3-4-times daily x1 with 4 refills, and for Bilateral L3-4, L5-S1 MBB's under fluoroscopy. Utilization Review (UR) on 11/10/2014 denied a request for compound cream with 4 refills, and for Bilateral L3-4, L5-S1 MBB's under fluoroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound Cream Diclofenac 5%, Gabapentin 6%, Baclofen 2%, Cyclobenaprine 2%, Bupivacaine 1%, Lidocaine 5%, and Fluticasone 1% apply 3-4 times a day times 1 with 4 refills: Upheld

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

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

Decision rationale: This patient presents with chronic low back pain with radiation of pain to the greater trochanter. The current request is for compound cream Diclofenac 5%, Gabapentin 6%, Baclofen 2%, cyclobenzaprine 2%, Bupivacaine 1%, lidocaine 5% and Fluticasone 1% apply 3-4-times daily x1 with 4 refills. The MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." MTUS states that Lidocaine is only approved in a patch form. Furthermore, Gabapentin and cyclobenzaprine is not recommendation in any topical formulation; therefore, the entire compound topical cream is rendered invalid. This topical compound medication is not medically necessary.

Bilateral L3-4, L5-S1 Medial Branch Block under fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Facet Joint Radiofrequency Neurotomy.

Decision rationale: This patient presents with chronic low back pain with radiation of pain to the greater trochanter. The current request is for Bilateral L3-4, L5-S1 MBB's under fluoroscopy. ACOEM Guidelines do discuss facet joint syndrome but does not support facet joint injections. ODG allows for facet diagnostic evaluation of facet joints but not therapeutic injection of the facet joints. Evaluation of facet joints is recommended when radicular symptoms are not present. ODG states RF ablation is under study, and there are conflicting evidence available as to the efficacy of its procedure and approval of treatment should be made on a case-by-case basis. In this case, the treating physician notes low back pain that radiates down to the greater trochanter. Facet block injections are indicated for patients with non-radicular symptoms. This request is not medically necessary.