

Case Number:	CM14-0205138		
Date Assigned:	12/17/2014	Date of Injury:	02/20/2008
Decision Date:	02/06/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	12/08/2014

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 Occupational 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:

According to the records made available for review, this is a 56-year-old female with a 2/20/08 date of injury. At the time (10/16/14) of request for authorization for Retrospective Naprosyn 550mg #60 with 1 refill, Qty: 120 (DOS: 10/16/14), Retrospective GebaKetoLido cream #1 with 1 refill, Qty: 2 (DOS: 10/16/14), and Lumbar MRI, QTY: 1, there is documentation of subjective (chronic low back pain) and objective (height of 5'5", weight of 244 pounds, and blood pressure of 155/88) findings, imaging findings (Reported MRI of the lumbar spine (6/20/11) revealed disc bulge at L4-5 with mild bilateral foraminal stenosis and minimal amount of facet hypertrophy on the right; and 7.66; report not available for review), current diagnoses (chronic lumbar sprain/strain with bilateral L5 radiculopathy and rule out urinary incontinence), and treatment to date (ongoing therapy with Naprosyn since at least 7/18/14). Regarding Retrospective Naprosyn 550mg #60 with 1 refill, Qty: 120 (DOS: 10/16/14), there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Naprosyn use to date. Regarding Lumbar MRI, QTY: 1, there is no documentation of a diagnosis/condition (with supportive objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Naprosyn 550mg #60 with 1 refill, Qty: 120 (DOS:10/16/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic lumbar sprain/strain with bilateral L5 radiculopathy and rule out urinary incontinence. In addition, there is documentation of chronic low back pain. However, given documentation of ongoing treatment with Naproxen since at least 7/18/14, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Naprosyn use to date. Therefore, based on guidelines and a review of the evidence, the request for Retrospective Naprosyn 550mg #60 with 1 refill, Qty: 120 (DOS:10/16/14) is not medically necessary.

Retrospective GebaKetoLido cream #1 with1 refill, Qty: 2 (DOS: 10/16/14): 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 Analgesics Page(s): 111-113.

Decision rationale: An online search identifies Gaba/Keto/Lido as compounded topical medication consisting of Gabapentin, Ketoprofen, and Lidocaine. MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of chronic lumbar sprain/strain with bilateral L5 radiculopathy and rule out urinary incontinence. However, the requested compounded medication consists of at least one drug (Gabapentin, Ketoprofen, and Lidocaine) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Retrospective GebaKetoLido cream #1 with1 refill, Qty: 2 (DOS: 10/16/14) is not medically necessary.

Lumbar MRI, QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Acute & Chronic, MRIs (magnetic resonance imaging)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Other Medical Treatment Guidelines: Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of chronic lumbar sprain/strain with bilateral L5 radiculopathy and rule out urinary incontinence. However, despite documentation of subjective findings (chronic low back pain), and given no documentation of objective findings to the lumbar spine, there is no documentation of a diagnosis/condition (with supportive objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for Lumbar MRI, QTY: 1 is not medically necessary.