

Case Number:	CM14-0205377		
Date Assigned:	12/15/2014	Date of Injury:	07/20/2010
Decision Date:	02/09/2015	UR Denial Date:	11/18/2014
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 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:

The patient is a 50 year old female with an injury date of 07/20/10. The 10/30/14 progress report states that the patient presents with increasing pain over the lower back particularly over the tailbone region and lower extremities, left greater than right. There is increased weakness affecting the left leg. She also presents with neck and right shoulder pain. With medication pain is rated 7/10 and without 10/10. As of 10/28/14 the patient is temporarily totally disabled for 6 weeks. Examination reveals exquisite tenderness over the C7-T1 junction with muscle spasm. Examination of the lumbar spine shows moderate bilateral lumbar paraspinous tenderness from L1 to S1 with tenderness over the lower thoracic regions with palpable muscle spasms present as well as tenderness over the sacrococcygeal region. Straight leg raise is positive left and right. There is limited range of motion of the upper extremity that has improved following surgery with continued weakness with forward flexion, abduction and grip strength. The patient's diagnoses include: 1. Cervical spine sprain/strain with right upper extremity radicular symptoms. 2. Cervical stenosis moderate C5-C6 per MRI 08/22/133. S/p right shoulder arthroscopy 06/12/144. S/p right shoulder manipulation 12/26/135. Multilevel lumbar degenerative disc disease s/p L4-S1 fusion 10/23/13.6. L5-S1 3-4 mm extradural defect contributing to left foraminal compromise touching the left L5 nerve root per MRI 07/30/137. EMG evidence of chronic left L4 radiculopathy (11/01/11)8. Left hip sprain/strain. The patient has received significant physical therapy. She received open repair of rotator cuff 12/26/13, by [REDACTED]. Current medications are listed as Percocet and Ibuprofen. The utilization review dated 11/18/14 denied transportation to and from the surgery center as there is no report confirming there is no personal means of transportation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325MG, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For Use Of Opioids Page(s): 88-89, 76-78; 60-61.

Decision rationale: The patient presents with increasing lower back pain especially over the tailbone and lower extremities along with neck and right shoulder pain. Pain is rated 7/10 with medications and 10/10 without. The current request is for Percocet 10/325MG, #90 (Oxycodone, an opioid) per RFA of 11/07/14. The 11/18/14 utilization review modified this request from #90 to # 60. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The reports provided show the patient was prescribed this medication as of 12/04/14. Percocet was discontinued per the 06/03/14 report due to severe constipation and Norco was started. Norco was discontinued per the 09/04/14 report and Percocet was restarted. Pain is routinely assessed through the use of pain scales. Reports from 05/06/14 to 10/30/14 consistently rate pain as 7/10 with medications and 10/10 without. On 10/30/14 the treater states, "She continues to note 30% improvement in overall pain as well as improvement in function. She states that without medication she would be unable to attend physical therapy to improve her range of motion." This report further states the patient notes significant improvement in back pain and improves ADL's such as cooking, housekeeping, cleaning and grocery shopping. The treater also states, "Without medication she notes a significant decrease in quality of life and ability to participate in ADLs." Opiate management issues are partially addressed. This report states the patient shows no evidence of drug seeking behavior, there is a signed opioid agreement, the patient is counseled on the risks and benefits of medications, and UDS shows compliance with prescribed medications. However, the 07/13/14 Urine Toxicology report provided states test results for Hydrocodone, Hydromorphone and Norhydrocodone were not expected based on prescribed medications as provided. The reports do not explain this inconsistent result. No outcome measures are provided. In this case, opiate management issues are not fully documented due to lack of explanation of inconsistent results. This request is for #90 versus the certified #60. The request is not medically necessary.

KGL Cream, #240G: 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 and topical creams Page(s): 111, 112.

Decision rationale: The patient presents with increasing lower back pain especially over the tailbone and lower extremities along with neck and right shoulder pain. Pain is rated 7/10 with medications and 10/10 without. The current request is for KGL Cream, #240G per RFA of 11/07/14. MTUS Topical Analgesics guidelines pages 111 and 112 has the following regarding topical creams, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS further states, "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis." MTUS guidelines page 112 state regarding Lidocaine, "Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." The 10/30/14 report states the requested medication is for the treatment of neuropathic pain that reports show is present in this patient. However, this compounded topical medication contains Ketoprofen that is not approved for topical applications as well as Gabapentin that MTUS specifically states is not recommended in the topical cream section. Furthermore, the medication contains lidocaine that is approved only in patch form for neuropathic pain. Therefore, this medication is not recommended by MTUS and is not medically necessary.

Transportation to and from Surgery Center: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Transportation (to & from appointments).

Decision rationale: The patient presents with increasing lower back pain especially over the tailbone and lower extremities along with neck and right shoulder pain. Pain is rated 7/10 with medications and 10/10 without. The current request is for Transportation to and from Surgery Center per RFA of 11/07/14. ODG guidelines discuss transportation to and from appointments in the Knee and Leg Chapter. It is recommended for medically necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. The utilization review states that the request for caudal ESI has been certified. This request is for transportation to the surgery center for this procedure per the 10/30/14 report. However, the treater does not explain why the patient requires this transportation. There is no discussion of disabilities that prevent self-transport. In this case, the request is not medically necessary.