

Case Number:	CM14-0206950		
Date Assigned:	01/30/2015	Date of Injury:	10/12/2004
Decision Date:	04/02/2015	UR Denial Date:	11/15/2014
Priority:	Standard	Application Received:	12/10/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Internal Medicine

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 55 year old male, who sustained an industrial injury on 10/13/2004. He reported back and shoulder pain. Diagnoses include status post bilateral rotator cuff repair, cervical sprain, right knee sprain and left knee sprain. Treatments to date include bilateral rotator cuff repair, physical therapy and medication management. A progress note from the treating provider dated 10/30/2014 indicates the injured worker reported low back pain and left shoulder and bilateral knee pain. On 11/15/2014, Utilization Review non-certified the request for magnetic resonance imaging of the lumbar spine, electromyography (EMG) of the bilateral lower extremities, topical compound of Ketoprofen cream, topical compound of Gabapentin cream, topical compound of Tramadol, Naprosyn 550 mg #60, Prilosec 20 mg #90, Xanax 1mg #60 and Norco 10/325 mg #60, citing Official Disability Guidelines and MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI - lumbar spine between 10/30/14 and 1/12/15: 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: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRIs (magnetic resonance imaging).

Decision rationale: MTUS recommends Lumbar spine x rays in patients with low back pain only when there is evidence of red flags for serious spinal pathology. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. Per guidelines, repeat MRI is recommended when there is significant change in symptoms and/or findings suggestive of significant pathology, such as tumor, infection, fracture, neurocompression or recurrent disc herniation. The injured worker complains of persistent radicular low back pain. The treating physician requests a repeat MRI to rule out the possibility of a new lesion at a lumbar spine level above the previous L5-S1 fusion. However, documentation fails to show objective findings of specific nerve compromise on physical examination and there is no reference to repeat surgery being considered. The request for MRI - lumbar spine between 10/30/14 and 1/12/15 is not medically necessary per guidelines.

EMG/NCV of lower extremities between 10/30/14 and 1/12/15: 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: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Special Studies and Diagnostic and Treatment Consideration, page 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter.

Decision rationale: Guidelines state that Electromyography (EMG) / nerve conduction studies (NCVs) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks , and to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy. However, there is minimal justification for performing EMGs / NCVs when a patient is presumed to have symptoms on the basis of radiculopathy. The injured worker presents with ongoing radicular low back pain and previous EMG indicated L5-S1 radiculopathy. With guidelines not being met, the request for EMG/NCV of lower extremities between 10/30/14 and 1/12/15 is not medically necessary.

topical compound Ketaprofen cream between 10/30/14 and 1/12/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, pg 111.

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Per guidelines,

Ketoprofen is not currently FDA approved for a topical application. The request for topical compound Ketoprofen cream between 10/30/14 and 1/12/15 is not medically necessary by MTUS.

topical compound Gabapentin cream between 10/30/14 and 1/12/15: Upheld

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

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

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Per guidelines, the use of topical Gabapentin is not recommended. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for topical compound Gabapentin cream between 10/30/14 and 1/12/15 is not medically necessary by MTUS.

topical compound Tramadol cream between 10/30/14 and 1/12/15: Upheld

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

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

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Furthermore, there are no established guidelines regarding the use of Topical Tramadol for the treatment of chronic pain. The request for topical compound Tramadol cream between 10/30/14 and 1/12/15 Tramadol is not medically necessary due to lack of supporting guidelines.

Naprosyn 550 mg. #60 between 10/30/14 and 1/12/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs Page(s): 67.

Decision rationale: MTUS states that Non-steroidal anti-inflammatory drugs (NSAIDs) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The injured worker is diagnosed with gastro-esophageal reflux disease and the reported low back pain, left shoulder

and bilateral knee pain is chronic and ongoing, Documentation fails to show significant improvement in pain or function, therefore, continued use of Naprosyn is not medically appropriate. The request for Naprosyn 550 mg. #60 between 10/30/14 and 1/12/15 is not medically necessary by MTUS.

Prilosec 20 mg. #90 between 10/30/14 and 1/12/15: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: MTUS recommends the combination of Non-steroidal anti-inflammatory drugs (NSAIDs) and Proton Pump Inhibitors (PPIs) for patients at risk for gastrointestinal events. Documentation supports that the injured worker is diagnosed with gastro-esophageal reflux disease and has been treated with NSAIDS chronically. With the possible risk of the injured worker developing a gastrointestinal event, the request for Prilosec 20 mg. #90 between 10/30/14 and 1/12/15 is medically necessary.

Xanax 1 mg. #60 between 10/30/14 and 1/12/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Per MTUS, Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Their use should be limited to 4 weeks. Documentation reveals that the injured worker has been prescribed Xanax for over six months prior to the date of the request under review. The request for Xanax 1 mg. #60 between 10/30/14 and 1/12/15 is not medically necessary by MTUS.

Norco 10/325 mg. #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74 ? 82.

Decision rationale: MTUS states that opioids are not generally recommended as a first-line therapy for some neuropathic pain. When prescribed, ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented. Assessment for the likelihood that the patient could be weaned from opioids is recommended if

there is no improvement in pain and function. The injured worker complaints of persistent radicular low back pain, left shoulder and bilateral knee pain and documentation fails to demonstrate adequate improvement in pain or level of function. In the absence of significant response to treatment, the request for Norco 10/325 mg. #60 is not medically necessary.