

Case Number:	CM14-0209144		
Date Assigned:	12/22/2014	Date of Injury:	07/01/2008
Decision Date:	02/17/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/15/2014

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 Pain 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:

This is a patient with a date of injury of 7/1/08. A utilization review determination dated 11/21/14 recommends non-certification/modification of chiropractic, pain management consultation (epidural injections), urinalysis, and topical medications. 10/31/14 medical report identifies pain in the neck with radiating to the LUE with numbness and tingling, burning pain in the left shoulder, and low back pain. Medications are helping. On exam, there is antalgic gait, limited cervical ROM, mildly positive head compression sign, AC joint tenderness, limited shoulder ROM with positive Neer's and impingement sign, lumbar tenderness with limited ROM and 4+ quadriceps and hamstring. Patellar tracking is abnormal on the right and patellar grind maneuver is positive. Tenderness is present with slight weakness on extension secondary to mild pain. Patient went to a chiropractor 2-3 months prior with "good benefits." Patient has not had cervical ESI in approximately one year.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Chiropractic Therapy Sessions to Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chiropractic Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60 of 127.

Decision rationale: Regarding the request for chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, the provider noted that the prior treatment gave good benefit, but there is no clear indication of specific objective functional improvement with the prior treatment. In the absence of clarity regarding the above issues, the currently requested chiropractic care is not medically necessary.

Pain Management Specialist Consultation (Epidural Injections): 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 Epidural steroid injections (ESIs) Page(s): 46 of 127.

Decision rationale: Regarding the request for pain management consultation for epidural injections, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Regarding repeat epidural injections, guidelines state that repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. Within the documentation available for review, there is no indication of current findings of radiculopathy and at least 50% pain relief with associated functional improvement and reduction of medication use for at least 6 weeks from previous epidural injections. As such, there is no clear indication for a pain management consultation for the purpose of repeating epidural injection. In light of the above issues, the currently requested pain management consultation for epidural injections is not medically necessary.

Flurbiprofen 20%/Baclofen 2%/Cyclobenzaprine 2% cream 120grams, apply 1-2 grams BID: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Regarding the request for flurbiprofen/baclofen/cyclobenzaprine, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Muscle relaxants are not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested flurbiprofen/baclofen/cyclobenzaprine is not medically necessary.

Retrospective Request for Urinalysis: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going Management of Opioid use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79 and 99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Urine Drug Testing

Decision rationale: Regarding the request for urinalysis, CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, there is no documentation of the date and results of prior testing and current risk stratification to identify the medical necessity of drug screening at the proposed frequency. In light of the above issues, the currently requested urinalysis is not medically necessary.

Gabapentin 10%/ Cyclobenzaprine 4%/Ketoprofen 10%/Capsaicin 0.0375%/Menthol 5%/Camphor 2% cream 120grams, Apply 1-2 grams BID: 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 Page(s): 111-113 of 127.

Decision rationale: Regarding the request for gabapentin/cyclobenzaprine/ketoprofen/capsaicin/menthol/camphor, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical

treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical ketoprofen is "not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis." Topical lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." Additionally, it is supported only as a dermal patch. Capsaicin is "Recommended only as an option in patients who have not responded or are intolerant to other treatments." Muscle relaxants and antiepilepsy drugs are not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested gabapentin/cyclobenzaprine/ketoprofen/capsaicin/menthol/camphor is not medically necessary.