

<b>Case Number:</b>	CM15-0185762		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	10/21/2014
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	08/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management, Occupational 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 63 year old male who sustained an industrial injury on 10-21-2014. The injured worker was diagnosed with cervical disc protrusion C4-C5 and C6-C7 with moderate to severe spinal stenosis, cervical spondylosis with early myelopathy and lumbar stenosis at L2-L3 and L4- L5-S1. According to the treating physician's progress report on 07-24-2015, the injured worker continues to experience neck pain with radiation to both upper extremities with some clumsiness of his hands and low back pain with radiation to both lower extremities with intermittent balance disturbance. Examination of the cervical spine demonstrated bilateral paraspinal tenderness C4 through C7 and bilateral upper trapezii tenderness. Range of motion was decreased in all directions with motor strength and sensation intact in the upper extremities. Spurling's produced neck pain on the right side. Examination of the lumbar spine demonstrated tenderness along the lumbosacral junction and right superior iliac crest with forward flexion at 45 degrees and extension at 20 degrees with increased pain. Motor strength and sensory were within normal limits in the bilateral lower extremities. Quadriceps and Achilles reflexes were decreased bilaterally. Straight leg raise was documented at 80 degrees bilaterally. Prior treatments included diagnostic testing with recent Otorhinolaryngology medical-legal evaluation on 06-24-2015, magnetic resonance imaging (MRI) of the brain, cervical and lumbar spine magnetic resonance imaging (MRI), neurology consultation, physical therapy and medications. The injured worker may return to work without limitations or restrictions. Current medications were listed as Cyclobenzaprine and Naproxen. Treatment plan consists of an authorized ENT

specialist evaluation, an authorized second opinion with a spinal surgeon and on 08-20-2015 the provider requested authorization for one lumbar epidural steroid injection at L2-L3, Flurbiprofen-Lidocaine 20%-5%, 150gm, Gabapentin-Amitriptyline-Capsaicin, 10% - 5% -- 0.025%, 150gm and Cyclobenzaprine-Lidocaine 10%/-5%, 150gm. On 08-21-2015 the Utilization Review determined the request for one lumbar epidural steroid injection at L2-L3, Flurbiprofen-Lidocaine 20%-5%, 150gm; Gabapentin-Amitriptyline-Capsaicin, 10% - 5% - 0.025%, 150gm and Cyclobenzaprine-Lidocaine 10%/-5%, 150gm were not recommended for certification.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **One lumbar epidural injection at L2-L3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Criteria for the use of epidural steroid injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** MTUS 2009 states that epidural steroid injections are an option to treat radicular symptoms with corresponding anatomic findings. This request for an epidural steroid injection does not adhere to guidelines since there is no evidence of foraminal nerve root compression described in the medical records for which epidural steroid injections would be useful. This request for an epidural steroid injection is not medically necessary.

#### **Flurbiprofen/Lidocaine 20%/5%, 150gm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** MTUS 2009 recommends against the use of compounded topical agents since they have no proven efficacy or evidence of safety. This compounded topical agent's use does not adhere to MTUS 2009. Topical NSAIDS are only recommended for short term use over superficial joints. This agent is requested for use on the lower back which is not supported by MTUS 2009 for topical NSAIDS. This request for Lidocaine/Flurbiprofen topical agent is not medically necessary.

#### **Gabapentin/Amitriptyline/Capsaicin, 10%/ 5%/ 0.025%, 150gm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** MTUS 2009 recommends against the use of compounded topical agents since they have no proven efficacy or evidence of safety. It also states that any agent containing Gabapentin and/or Amitriptyline should not be used. The medical records do not explain why evidence based care should not be provided in this case. The medical records also do not explain why an exception to MTUS 2009 recommendations should be made in this case. Therefore the request is not medically necessary.

**Cyclobenzaprine/Lidocaine 10%/ 5%, 150gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** MTUS 2009 recommends against the use of compounded topical agents since they have no proven efficacy or evidence of safety. It also states that any agent containing cyclobenzaprine should not be used. The medical records do not explain why a topical agent containing cyclobenzaprine should be used in this case when the guidelines recommend against its use. This request for topical cyclobenzaprine/lidocaine is not medically necessary.