

<b>Case Number:</b>	CM15-0204624		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	01/06/2012
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	10/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 71 year old female, who sustained an industrial injury on 1-6-12. Medical records indicate that the injured worker is undergoing treatment for lumbar degeneration of intervertebral disc, lumbar radiculopathy and cervical radiculopathy. The injured worker is currently not working. On (9-24-15) the injured worker reported that her symptoms have not changed since the prior visit. The injured worker noted neck pain which radiated down the left arm and left lower extremity. The pain was rated 5-6 out of 10 on the visual analogue scale. The injured worker also noted back pain with weakness in the bilateral lower extremities. The back pain was rated 7 out of 10. The injured workers pain fluctuated with activity. The injured worker also noted that she lives alone and cannot perform her activities of daily living without an increase in pain. Objective findings noted diffuse cervical, thoracic and lumbar tenderness over the midline and paraspinal muscles and a severely decreased cervical flexion, extension, rotation and lateral bend. Range of motion of the thoracic and lumbar spine was moderately decreased in all planes, greatest in the lumbar extension. A Hoffman's, Babinski, straight leg raise, Lasegue's maneuver and Lhermitte's sign were negative. Treatment and evaluation to date has included medications, lumbar MRI, CT scan cervical spine, lumbar x-rays, cervical epidural steroid injections, cervical medial branch block, cervical radiofrequency ablation, lumbar transforaminal epidural steroid injection, acupuncture treatments, physical therapy and a cervical fusion. Current medications include Norco, Dexilant, Lidoderm patch, Robaxin and Linzess. Treatments tried and failed include Botox injections. The request for authorization dated 9-24-15 includes requests for Ketoprofen 20% # 1 and Home Health care six hours a day-two days a week # 8. The Utilization Review documentation dated 10-9-15 non-certified the requests for Ketoprofen 20% # 1 and Home Health care six hours a day-two days a week # 8.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Home health 6 hours/day 2 days/week (in weeks) qty: 8:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

**Decision rationale:** The California MTUS section on home health states: Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. (CMS, 2004) The provided documentations does not show the patient to be home bound either permanently or on an intermittent basis. Therefore the request is not medically necessary.

**Ketoprofen 20% qty: 1:** Upheld

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

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

**Decision rationale:** The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Topical analgesic NSAID formulations are not indicated for long-term use and have little evidence for treatment of the spine, hip or shoulder. This patient does not have a diagnosis of osteoarthritis or neuropathic pain that has failed first line treatment options but rather the diagnosis of back pain and radiculopathy. Therefore criteria for the use of topical NSAID therapy per the California MTUS have not been met and the request is not medically necessary.

