

Case Number:	CM15-0087313		
Date Assigned:	05/13/2015	Date of Injury:	07/12/2007
Decision Date:	09/18/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	05/06/2015

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: Preventive Medicine, 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 female, who sustained an industrial injury on 7/12/07. She reported tripping while rushing to an emergency and injuring her ankles, feet, lower back, left lower leg and left hip. The injured worker was diagnosed as having lumbar degenerative joint disease, insomnia, anxiety, L5-S1 radiculopathy and bilateral ankle synovitis with impingement. Treatment to date has included a lumbar epidural injection on 2/3/15, a lumbar MRI showing L4-L5 and L5-S1 disc herniation, an EMG/NCS of the lower extremities and bilateral hip x-rays. She is also been using Norco and Xanax since at least 12/18/14. As of the PR2 dated 3/18/15, the injured worker reports improvement in her back and legs with first epidural injection. She indicated that the epidural effects lasted for 30 days. Objective findings include lumbar flexion 40 degrees, decreased sensation and a positive straight leg raise test. The treating physician requested Compazine 50mg #60, Xanax 1mg #60, Norco 10/325mg #60, Ketoprofen cream 20% 30 gram, Gabapentin cream 10% 30 gram, Tramadol cream 20% 30 gram, urinalysis toxicology screen, a solar-care heating system, an x-force stimulator with garments, a second left L5-S1 epidural injection and a third left L5-S1 epidural injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compazine 50mg QTY: 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/mtm/compazine.html>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Promethazine.

Decision rationale: Prochlorperazine oral (Compazine) is used to treat psychotic disorders such as schizophrenia. It is also used to treat anxiety, and to control severe nausea and vomiting. The Official Disability Guidelines state that Compazine is not recommended for nausea and vomiting secondary to chronic opioid use and there is no documentation of schizophrenia. Compazine 50mg QTY: 60 is not medically necessary.

Xanax 1mg QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, Weaning of Medications Page(s): 24, 124.

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

Decision rationale: Xanax (alprazolam) is a benzodiazepine medication used to treat anxiety and panic disorders. The MTUS states that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of Xanax. Xanax 1mg QTY: 60 is not medically necessary.

Norco 10/325mg QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49, Chronic Pain Treatment Guidelines Opioids, Weaning of Medications Page(s): 78-81, 124. Decision based on Non-MTUS Citation ACOEM Second Edition, 2004, Chapter 6, page 115.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. Norco 10/325mg QTY: 60 is not medically necessary.

Topical Ketoprofen Cream 20% 30gm QTY: 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: The compound contains ketoprofen and is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. It is not recommended by the MTUS. Topical Ketoprofen Cream 20% 30gm QTY: 1 is not medically necessary.

Topical Gabapentin Cream 10% 30gm QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Gabapentin Page(s): 113.

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

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Topical Gabapentin Cream 10% 30gm QTY: 1 is not medically necessary.

Topical Tramadol Cream 20% 30gm QTY: 1: 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 Page(s): 111-113.

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Tramadol is not recommended. There is no peer-reviewed literature to support the use of topical tramadol. Topical Tramadol Cream 20% 30gm QTY: 1 is not medically necessary.

Urinalysis Toxicology Screen QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

Decision rationale: The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. There is no documentation in the medical record that a urine drug screen was to be used for any of the above

indications. Urinalysis Toxicology Screen QTY: 1 is not medically necessary.

Solar-Care Heating System (Indefinite Use) QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Heat Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Heat therapy.

Decision rationale: The Official Disability Guidelines recommend at-home local applications of continuous low-level heat therapy for acute low back pain. Active warming reduces acute low back pain during rescue transport. Combining continuous low-level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control. There is moderate evidence that heat wrap therapy provides a small short-term reduction in pain and disability in acute and sub-acute low-back pain, and that the addition of exercise further reduces pain and improves function. The injury is no longer considered acute and there is no documentation of an exercise program. Solar-Care Heating System (Indefinite Use) QTY: 1 is not medically necessary.

X-Force Stimulator with Garments (Indefinite Use) QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 113-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: The X-Force Stimulator is a proprietary device that utilizes a unique electrical signal to deliver monophasic, peaked impulses directly to the joint. The device is a dual modality unit, offering TEJS and TENS functions. A TENS unit without TEJS stimulation is the recommended treatment by the MTUS. X-Force Stimulator with Garments (Indefinite Use) QTY: 1 is not medically necessary.

Second Left L5-S1 Epidural Steroid Injection QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the therapeutic phase, 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. The medical record lacks sufficient documentation

and does not support a referral request. Second Left L5-S1 Epidural Steroid Injection QTY: 1 is not medically necessary.

Third Left L5-S1 Epidural Steroid Injection QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the therapeutic phase, 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. The medical record lacks sufficient documentation and does not support a referral request. Third Left L5-S1 Epidural Steroid Injection QTY: 1 is not medically necessary.