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| Case Number: | CM14-0119219 | | |
| Date Assigned: | 08/06/2014 | Date of Injury: | 02/19/2002 |
| Decision Date: | 10/17/2014 | UR Denial Date: | 07/08/2014 |
| Priority: | Standard | Application Received: | 07/29/2014 |

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

Patient is a 59-year-old male who has submitted a claim for status post anterior cervical discectomy and fusion, status post right shoulder surgery, right shoulder internal derangement, right shoulder rotator cuff syndrome, bilateral upper extremity radiculitis, thoracic spine disc syndrome, low back syndrome, bilateral lower extremity radiculitis, sexual dysfunction, and intractable pain associated with an industrial injury date of 2/19/2002. Medical records from 2012 - 2014 were reviewed. The patient complained of neck pain, right shoulder pain, and low back pain, rated 8/10 in severity. Physical examination showed a weak right grip strength measured at 8/4/4 kg, versus 20/20/18 at the left. Patient was right-handed. Range of motion of the cervical spine was limited secondary to spasm and pain. Range of motion of both shoulders was likewise limited and painful. Impingement test was positive at the right shoulder. Right upper extremity muscles were graded 5 minus/5 in strength. Deep tendon reflexes were intact. Examination of the thoracolumbar spine showed spasm, limited and painful range of motion. Straight leg raise test was positive bilaterally. Straight leg raise test on the left caused thoracic spine pain. Motor strength and reflexes of the lower extremities were intact. MRI of the cervical spine, dated 7/18/2014, demonstrated mild to moderate neural foramina narrowing at C2 to C3. At C3 to C4, there was mild disc desiccation with moderate to severe left facet degenerative changes, with mild to moderate left neural foramina narrowing. MRI of the lumbar spine, dated 7/18/2014, demonstrated facet degenerative changes with moderate bilateral lateral recess and neural foraminal narrowing at L4 to L5. MRI of the thoracic spine, dated 5/19/2013, demonstrated disc protrusion at T1-2 T2 level with bilateral neural foramina stenosis exerting pressure over the left and right T1 exiting nerve roots. There was also narrowing of the right neural foramina effacing the right T2 and T3 exiting nerve roots. Treatment to date has included cervical spine surgery on 9/24/2014, right shoulder surgery, physical therapy, home exercise

program, and medications such as topical creams, Robaxin, Percocet, and Lidocaine patch. Utilization review from 7/8/2014 denied the request for MRI of the thoracic spine because of lack of significant clinical findings pertaining to the thoracic spine; denied TGHOT (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%, Capsaicin 0.05%) 180gm and Fluriflex (Flurbiprofen 10%, Cyclobenzaprine 10%) 180gm due to lack of published studies concerning its efficacy and safety; and denied neurosurgical consultation because of no evidence of severe disabling symptoms or activity limitations to warrant such consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRI

Decision rationale: As stated on pages 303-304 of the ACOEM Practice Guidelines referenced by CA MTUS, imaging of the thoracic spine is recommended in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration for surgery. In addition, Official Disability Guidelines recommends MRI for uncomplicated back pain, with radiculopathy, after at least 1 month of conservative therapy. In this case, patient complained of back pain, rated 8/10 in severity. Examination of the thoracolumbar spine showed spasm, and painful / limited range of motion. Straight leg raise test on the left caused thoracic spine pain. MRI of the thoracic spine, dated 5/19/2013, demonstrated disc protrusion at T1-2 T2 level with bilateral neural foramina stenosis exerting pressure over the left and right T1 exiting nerve roots. There was also narrowing of the right neural foramina effacing the right T2 and T3 exiting nerve roots. However, there was no clear indication for a repeat imaging study based on the records submitted. There was no worsening of subjective complaints or objective findings to warrant repeat testing. A surgical treatment plan was not mentioned. Therefore, request for MRI of the Thoracic Spine is not medically necessary.

TGHOT (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%, Capsaicin 0.05%) 180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin; Topical Analgesics Page(s): 28 - 29; 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Topical Salicylates

Decision rationale: TGHOT contains Tramadol, Gabapentin, Menthol, Camphor, and 0.05% Capsaicin. As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. The topical formulation of tramadol does not show consistent efficacy. CA MTUS does not support the use of opioid medications and gabapentin in a topical formulation. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. The guidelines do not address camphor. CA MTUS Chronic Pain Medical Treatment Guidelines identifies on page 28 that topical Capsaicin is only recommended as an option if there was failure to respond or intolerance to other treatments. The guideline states there is no current indication that an increase over a 0.025% formulation of capsaicin would provide any further efficacy. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains tramadol, gabapentin, and 0.05% capsaicin, which are not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. Therefore, the request for TGHOT (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%, Capsaicin 0.05%) 180gm is not medically necessary.

Fluriflex (Flurbiprofen 10%, Cyclobenzaprine 10%) 180gm: 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): 111-113.

Decision rationale: Fluriflex contains Flurbiprofen 10% and cyclobenzaprine 10%. According to CA MTUS Chronic Pain Medical Treatment Guidelines pages 111-113, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Cyclobenzaprine is not recommended for use as a topical analgesic. In addition, there is little to no research as for the use of Flurbiprofen in compounded products. In this case, patient was prescribed topical products as adjuvant therapy to oral medications. However, the compounded product contains Flurbiprofen and Cyclobenzaprine, which are not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. Therefore, the request for Fluriflex (Flurbiprofen 10%, Cyclobenzaprine 10%) 180gm is not medically necessary.

1 neurosurgical consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental

Medicine (ACOEM), 2nd Edition, (2004) <Chapter 7, Independent Medical Examinations and Consultations, page(s) <127>

Decision rationale: As stated on page 127 of the California MTUS ACOEM Independent Medical Examinations and Consultations Chapter, occupational health practitioners may refer to other specialists if the diagnosis is uncertain, or when psychosocial factors are present. In this case, patient complained of neck pain and low back pain, rated 8/10 in severity. Physical examination showed a weak right grip strength measured at 8/4/4 kg, versus 20/20/18 at the left. Patient was right-handed. Range of motion of the cervical spine was limited secondary to spasm and pain. Right upper extremity muscles were graded 5 minus/5 in strength. Deep tendon reflexes were intact. Examination of the thoracolumbar spine showed spasm, limited and painful range of motion. Straight leg raise test was positive bilaterally. Straight leg raise test on the left caused thoracic spine pain. Motor strength and reflexes of the lower extremities were intact. MRI of the cervical spine, dated 7/18/2014, demonstrated mild to moderate neural foramina narrowing at C2 to C3. At C3 to C4, there was mild disc desiccation with moderate to severe left facet degenerative changes, with mild to moderate left neural foramina narrowing. MRI of the lumbar spine, dated 7/18/2014, demonstrated facet degenerative changes with moderate bilateral lateral recess and neural foraminal narrowing at L4 to L5. MRI of the thoracic spine, dated 5/19/2013, demonstrated disc protrusion at T1-2 T2 level with bilateral neural foramina stenosis exerting pressure over the left and right T1 exiting nerve roots. There was also narrowing of the right neural foramina effacing the right T2 and T3 exiting nerve roots. Patient recently underwent cervical spine surgery on 9/24/2014 by an orthopedic surgeon. There was no clear indication for a neurosurgical consultation based on the medical records submitted. There was no worsening of subjective complaints and objective findings that may warrant referral to another specialist. The medical records did not reveal uncertainty or complexity of issues on his current medical condition. The medical necessity cannot be established due to insufficient information. Therefore, the request for Neurosurgical Consultation was not medically necessary.