

Case Number:	CM14-0098060		
Date Assigned:	08/08/2014	Date of Injury:	10/16/2002
Decision Date:	09/15/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/26/2014

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 Orthopedic Surgery and is licensed to practice in Texas. 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:

The injured worker is a 53 year old female who developed low back pain secondary to lifting trays of grapes on 10/16/02. The records indicate that the injured worker has received extensive conservative treatment over the years consisting of oral medications and physical therapy. The injured worker has declined most interventional procedures and several recommendations for surgery. The record includes an electrodiagnostic studies (EMG/NCV) dated 07/10/08 which was reported as negative. A newer study dated 04/19/14 reports a chronic active L5-S1 radiculopathy. MRI is reported to show a bilateral listhesis at L4-5 and mild anterolisthesis at L5-S1. She is noted to have posterior disc bulge with osteophytes at T10-11, L3-4, L4-5, and L5-S1. There is mild central canal stenosis at T10-11 and L4-5. There is mild foraminal stenosis on the right and moderate on the left at T10-11. There is mild foraminal stenosis on the right at L3-4. There is mild to moderate foraminal stenosis at L4-5 bilaterally. There is moderate foraminal stenosis at L5-S1 bilaterally. On physical examination dated 04/29/14, gross motor strength loss in the bilateral lower extremities is noted, subsequently recommended to undergo decompression and fusion. The record contains a utilization review determination dated 05/27/14 in which a request for decompression and fusion at L5-S1, topical cream Gabapentin, topical cream Ketoprofen, topical cream Tramadol, Flexeril 7.5 mg #90, Prilosec 20 mg #90 and physical therapy 2 x 6 weeks was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR SPINE DECOMPRESSION & FUSION L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion.

Decision rationale: The request for lumbar decompression and fusion at L5-S1 is not supported as medically necessary. The submitted clinical records indicate that the injured worker sustained a lumbar strain that was superimposed over degenerative disease. The records indicate that she has undergone conservative management over the year which has included oral medications, physical therapy and epidural steroid injections with reported progressively worsening symptoms. Records indicate that the injured worker has electrodiagnostic evidence of an L5-S1 radiculopathy. Imaging studies note the presence of a mild anterolisthesis at L5-S1 with a reported bilateral listhesis at L4-5. The record does not document lumbar flexion/extension views. The record does not include a preoperative psychiatric evaluation. It would further be noted that the requestor is not the operating surgeon. As such, the injured worker requires updated imaging, a psychiatric evaluation and re-evaluation by the operating surgeon to establish an appropriate surgical plan. Given the above, the request for lumbar decompression and fusion at L5-S1 is not medically necessary.

TOPICAL CREAM GABAPENTIN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Compounded Medications.

Decision rationale: The request for topical cream Gabapentin is not supported as medically necessary. The Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: Gabapentin which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended, and therefore, the request for Topical Cream Gabapentin is not medically necessary.

TOPICAL CREAM KETOPROFEN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Compounded Medications.

Decision rationale: The Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: Ketoprofen which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended, and therefore, the request for Topical Cream Ketoprofen is not medically necessary.

TOPICAL CREAM TRAMADOL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Compounded Medications.

Decision rationale: The request for topical cream Tramadol is not supported as medically necessary. The Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: Tramadol which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended, and therefore, the request for Topical Cream Tramadol is not medically necessary.

FELXERIL 7.5MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: The request for Flexeril 7.5 mg #90 is not supported as medically necessary. The most recent physical examinations do not document the presence of active myospasm for which this medication would be clinically indicated and as such, medical necessity has not been established.

PRILOSEC 20MG, #90: Upheld

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

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

Decision rationale: The request for Prilosec 20 mg #90 is not supported as medically necessary. The record provides no data which establishes that the injured worker has medication induced gastritis for which this medication would be indicated. As such, medical necessity has not been established.

Physical Therapy 2 X 6 WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.