

Case Number:	CM15-0111506		
Date Assigned:	06/18/2015	Date of Injury:	11/20/2010
Decision Date:	07/23/2015	UR Denial Date:	05/14/2015
Priority:	Standard	Application Received:	06/09/2015

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: Texas, California

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 was a 52 year old female, who sustained an industrial injury, November 20, 2010. The injured worker previously received the following treatments lumbar epidural steroid injection at L5-S1, Tramadol, EnovaRx cream, Omeprazole, topical cream and back brace. The injured worker was diagnosed with lumbar disk disease, lumbar radiculopathy, left ankle internal derangement disorder, insomnia, constipation, thoracic spine herniated nucleus pulposus, lumbar spine herniated nucleus pulposus, low back syndrome and psychiatric problems. According to progress note of June 18, 2015, the injured workers chief complaint was low back pain. The injured worker rated the pain at 5 out of 10. The worse pain was 7 out of 10. The injured worker had associated numbness and tingling into the bilateral hands, posterior knee, left calf, right calf, right posterior knee, right foot, right ankle, left ankle, left foot approximately 60% of the time. The injured worker was experiencing insomnia. The physical exam noted decrease range of motion in all plans. The Kemp's testing was positive bilaterally. The treatment plan included a lumbar spine MRI and a prescription for Flurbiprofen 20%/Baclofen 2%/Capsaicin 0.375%/Hyaluronic Acid 0.20%. Patient sustained the injury due to a slip and fall incident. The patient has had MRI of the lumbar spine on 12/27/12 and on 1/13/14 that revealed disc protrusion and foraminal narrowing and degenerative changes. The medication list include Tramadol, EnovaRx cream, Omeprazole, Flexeril and Norco. The patient has had urine drug screen on 5/7/15 that was negative for hydrocodone and Amphetamine. Other therapy done for this injury was not specified in the records provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20%/ Baclofen 2%/ Camphor 2%/ Dexamethasone 2%/ Menthol 2%/ Capsaicin 0.375%/ Hyaluronic Acid 0.20% 180grams #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain - Topical Analgesics, pages 111-112 Topical Analgesics.

Decision rationale: Flurbiprofen 20%/ Baclofen 2%/ Camphor 2%/ Dexamethasone 2%/ Menthol 2%/ Capsaicin 0.375%/ Hyaluron. According to the MTUS Chronic Pain Guidelines regarding topical analgesics state that the use of topical analgesics is "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." There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis. Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Non-neuropathic pain: "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." MTUS guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. Any trial of antidepressants and anticonvulsants for these symptoms were not specified in the records provided. Intolerance or contraindication to oral medications was not specified in the records provided. Evidence of diminished effectiveness of oral medications was not specified in the records provided. Baclofen is muscle relaxant. Per the cited guidelines, "Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." The medication Flurbiprofen is a NSAID. Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. There is also no evidence that menthol is recommended by the CA, MTUS, Chronic pain treatment guidelines. In addition, as cited above, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical Flurbiprofen, Capsaicin and menthol and Baclofen are not recommended by MTUS in this patient. The medication Topical compounded Flurbiprofen 20%/ Baclofen 2%/ Camphor 2%/ Dexamethasone 2%/ Menthol 2%/ Capsaicin 0.375%/ Hyaluron is not fully established in this patient. The request is not medically necessary.

MRI of the lumbar spine x1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, 289-290.

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 Treatment in Workers' Comp., online Edition Chapter: Low Back (updated 10/28/14) MRIs (magnetic resonance imaging).

Decision rationale: MRI of the lumbar spine x 1. Per the ACOEM low back guidelines cited below "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures)." ACOEM/MTUS guideline does not address a repeat MRI. Hence ODG is used. Per ODG low back guidelines cited below, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." The patient has had MRI of the lumbar spine on 12/27/12 and on 1/13/14 that revealed disc protrusion and foraminal narrowing and degenerative changes. Significant changes in objective physical examination findings since the last study, which would require a repeat study, were not specified in the records provided. Patient did not have any evidence of severe or progressive neurologic deficits that are specified in the records provided. Any finding indicating red flag pathologies were not specified in the records provided. The history or physical exam findings did not indicate pathology including cancer, infection, or other red flags. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. A detailed response to a complete course of conservative therapy including PT visits was not specified in the records provided. Previous PT visit notes were not specified in the records provided. A plan for an invasive procedure of the lumbar spine was not specified in the records provided. The medical necessity of the MRI of the lumbar spine x 1 is not fully established for this patient.

Interferential stimulator home unit rental 60 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page 118-120 Interferential Current Stimulation (ICS).

Decision rationale: Interferential stimulator home unit rental 60 days. Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) is "Not

recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." Per the cited guideline While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. Per the records provided, any indication listed above is not specified in the records provided. The records provided do not specify a response to conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts for this injury. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. Detailed response to previous conservative therapy was not specified in the records provided. The previous PT visit notes are not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications is not specified in the records provided. The medical necessity of the request for In Interferential stimulator home unit rental 60 days is not fully established in this patient.