

Case Number:	CM15-0117375		
Date Assigned:	06/25/2015	Date of Injury:	12/11/1996
Decision Date:	07/31/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/17/2015

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, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 59 year old male, who sustained an industrial injury on 12/11/1996. The injured worker was diagnosed as having intervertebral disc syndrome, lumbar radiculitis/sciatica, cervical sprain/strain with chronic myofascitis and chronic intermittent muscle tension headaches, and chronic carpal tunnel syndrome/de Quervain's bilateral hands. Treatment to date has included diagnostics and medications. On 11/20/2014, the injured worker complained of persistent and constant pain and spasm about his neck/upper back, middle back, and low back regions. Radiation was noted to his shoulder blades, buttocks, left hip, and both lower extremities (left greater than right). He reported difficulty getting medications for this work injury and was forced to go through his primary care insurance. He continued to suffer from numbness and tingling extending into his lower extremities, in addition to his upper extremities. He also reported insomnia secondary to pain and mild gastrointestinal distress with anti-inflammatory medication use. His pain was rated 8-9/10. Jamar grip strength was 20/15/20 on the right and 20/20/15 on the left. He was right hand dominant. Decreased range of motion was noted to the upper extremities and cervical and lumbar spines due to pain. Multiple x-rays and magnetic resonance imaging findings were referenced. His current medication regime was not noted. The treatment plan included compounded medicated creams to help decrease/minimize use of narcotic opioid medications and computerized strength and range of motion study to assess and quantify functional limitations.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective computerized strength and range of motion study, DOS 11/20/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Flexibility.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Chapter, Flexibility.

Decision rationale: The patient presents with diagnoses that include intervertebral disc syndrome, lumbar radiculitis/sciatica, cervical sprain/strain with chronic myofascitis and chronic intermittent muscle tension headaches and chronic carpal tunnel syndrome / de Quervain's bilateral hands. At the time of the requested treatment, the patient complained of persistent and consistent pain with associated muscle spasms about the neck or upper back, mid-back region. The neck and back pain continued to radiate. The patient continues to suffer from numbness and tingling extending distally into the bilateral lower extremities. The patient presented with decreased range of motion noted upon the extreme flexion extension and lateral bending bilaterally in the cervical and lumbosacral spine region secondary to pain. The current request is for Retrospective computerized strength and range of motion study, DOS 11/20/14. In the 11/20/14 (14B) report the treating physician states, "Authorization requested: computerized strength and range of motion study to further assess and objectively quantify the patient's functional limitations." MTUS Guidelines do not address ROM testing. ODG lumbar chapter for ROM (Flexibility) does not recommend computerized measures of the lumbar spine, which can be performed using an inclinometer that is reproducible, simple, practical and inexpensive. There is no documentation in the clinical history provided to indicate the medical necessity for a separate procedure for ROM testing outside of the standard routine part of a physical examination. The requested treatment is not medically necessary.

Retrospective compound medication Ketoprofen Microinized Powder, Gabapentin Powder, Capsaicin Powder, Menthol Crystals, Camphor Crystals, Pentravan Cream base, quantity unspecified, DOS 11/20/14: Upheld

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

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

Decision rationale: The patient presents with diagnoses that include intervertebral disc syndrome, lumbar radiculitis/sciatica, cervical sprain/strain with chronic myofascitis and chronic intermittent muscle tension headaches and chronic carpal tunnel syndrome/de Quervain's bilateral hands. At the time of the requested treatment, the patient complained of persistent and consistent pain with associated muscle spasms about the neck or upper back, mid-back region. The neck and back pain continued to radiate. The patient continues to suffer from numbness and tingling extending distally into the bilateral lower extremities. The current request is for

Retrospective compound medication Ketoprofen Micronized Powder, Gabapentin Powder, Capsaicin Powder, Menthol Crystals, Camphor Crystals, Pentravan Cream Base. In the 11/20/14 (14B) treating report the treating physician states, "Authorization requested: compound pharmaceutical muscle rub medications to help decrease/minimize usage of narcotic opioid medications." MTUS Guidelines give a general statement about compounded products: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The current request is for a compounded topical analgesic containing Ketoprofen. MTUS specifically states Ketoprofen is not FDA approved for topical applications. Therefore, any compounded product that contains Ketoprofen is not recommended. The requested treatment is not medically necessary.

Retrospective Compound Medication Diclofenac Sodium Powder, Flurbiprofen powder, Gabapentin powder, Tetracaine powder and Pentravan Cream Base, quantity unspecified, DOS 11/20/14: Upheld

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

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

Decision rationale: The patient presents with diagnoses that include intervertebral disc syndrome, lumbar radiculitis/sciatica, cervical sprain/strain with chronic myofascitis and chronic intermittent muscle tension headaches and chronic carpal tunnel syndrome/de Quervain's bilateral hands. At the time of the requested treatment, the patient complained of persistent and consistent pain with associated muscle spasms about the neck or upper back, mid-back region. The neck and back pain continued to radiate. The patient continues to suffer from numbness and tingling extending distally into the bilateral lower extremities. The current request is for Retrospective Compound Medication Diclofenac Sodium Powder, Flurbiprofen Powder, Gabapentin powder (Compound Medication: DFGTP). In the 11/20/14 (14B) treating report the treating physician states, "Authorization requested: compound pharmaceutical muscle rub medications to help decrease/minimize usage of narcotic opioid medications." MTUS Guidelines give a general statement about compounded products: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The current request is for a compounded topical analgesic containing Flurbiprofen. MTUS Guidelines do not support the usage of Flurbiprofen (NSAID) for the treatment of spine, hip, shoulder or neuropathic pain. Additionally, the current requested compound contains Gabapentin. MTUS specifically states that Gabapentin is not recommended under the topical analgesic section. Therefore, any compounded product that contains Flurbiprofen and/or Gabapentin is not consistent with MTUS Guidelines. The requested treatment is not medically necessary.