

Case Number:	CM15-0117477		
Date Assigned:	07/23/2015	Date of Injury:	09/09/2003
Decision Date:	08/20/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/18/2015

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: Connecticut, California, Virginia

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 71 year old female, who sustained an industrial injury on September 9, 2003. She reported cervical and lumbar spine injuries. The injured worker was diagnosed as having cervicobrachial syndrome, chronic pain syndrome, lumbar radiculopathy, and postlaminectomy syndrome. Diagnostic studies to date have included: on November 10, 2006, nerve conduction studies of the upper extremities revealed acute left cervical 5-6 radiculopathy. On January 9, 2013, an MRI of the lumbar spine revealed intervertebral disc displacement and degenerative changes of the lumbar spine. At lumbar 3-4, there was mild central canal stenosis at lumbar 2-3. There was moderate central canal stenosis, a 7 millimeter central disc protrusion with an associated subtle annular tear, and moderate right lateral recess encroachment with mild to moderate left lateral recess encroachment. There was moderate bilateral neural foraminal narrowing worse on the right where it was borderline moderate to marked. There was some abutment of the bilateral lumbar 4 nerve roots as they bud from the thecal sac (right side greater than left) due to posterior facet and ligamentum flavum hypertrophic changes. At lumbar 5-sacral 1, there was mild to moderate right lateral recess encroachment with moderate right-sided neural foraminal narrowing. There was 3-4 millimeter grade 1 anterolisthesis of lumbar 4 on lumbar 5 and 1 millimeter grade 1 anterolisthesis of lumbar 3 on lumbar 4. Surgeries to date have included: lumbar reconstruction in 2004 and partial vertebrectomy with anterior decompression of spinal cord and adjacent nerve roots at cervical 4 through cervical 6, anterior cervical interbody arthrodesis at cervical 4-5 and cervical 5-6, implant reconstruction of the vertebrectomy/interspace at cervical 4-5 and cervical 6-7, and multilevel anterior cervical spinal

instrumentation at cervical 4 through cervical 6 in 2007. Treatment to date has included a cane, a walker, a wheelchair, psychiatric care, podiatry care, cognitive behavioral therapy, acupuncture, trigger point injections, home occupational therapy, myofascial therapy, home care, and medications including oral analgesic, topical analgesic, muscle relaxant, anti-epilepsy, antidepressant, proton pump inhibitor, and non-steroidal anti-inflammatory. There were no noted previous injuries or dates of injury. Comorbid diagnoses included history of hypertension, osteoarthritis, hypercholesterolemia, seizures, asthma, unspecified headaches, insomnia, and depression. On October 14, 2014, the injured worker complained of continued moderate pain. She still experiences some intense pain. Associated symptoms include difficulty breathing, drowsiness, nausea, and lightheadedness. The physical exam revealed a slowed, stooped, wide-based gait. There was normal sitting and standing posture, normal transitions from sit to stand, and normal bed mobility. There was a 4 centimeter horizontal surgical scar of the cervical spine and tenderness, spasm, tight muscle band, and trigger point of the paravertebral muscles bilaterally. The bilateral Spurling's maneuver caused pain in the neck muscles without radicular symptoms. There was a 13 centimeter lumbar surgical scar and tenderness, spasm, tight muscle band, and trigger point of the paravertebral muscles bilaterally. The exams of muscle strength and reflexes were normal. There was decreased sensation to light touch over the medial hand and anterior thigh bilaterally and dysesthesias over medial hand, anterior thigh, and medial thigh bilaterally. The treatment plan includes home health care for 6 months. Her work status was described as permanent and stationary/maximum medical improvement (MMI). Requested treatments include: EMLA Cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Emla cream 2.5-2.5% with one refill: 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: The MTUS guidelines on Topical Analgesics describe topical treatment as an option; however, topicals are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The MTUS states specifically that any compound product that contains at least one drug (or class) that is not recommended is not recommended. Lidocaine is not recommended as a topical lotion or gel for neuropathic pain, categorizing the requested compound as not recommended by the guidelines. The lack of evidence to support use of topical compounds like the one requested makes the requested treatment not medically necessary per the MTUS.