

<b>Case Number:</b>	CM15-0170912		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	10/30/2012
<b>Decision Date:</b>	10/16/2015	<b>UR Denial Date:</b>	08/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/31/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 42 year old female who sustained an industrial injury on 10-30-2012 when she fell at work. She reported pain in her head, neck, back, right shoulder, hips and knees. On 02-24-2014 MRI of the left knee showed medial meniscus oblique tear involving the posterior horn, lateral meniscus oblique tear involving the posterior horn, lateral collateral ligament complex grade 1 sprain, quadriceps tendinosis and knee joint effusion. On 08-04-2014, MRI of the lumbar spine showed straightening of the lumbar lordosis, bilateral facet arthropathy, disc desiccation and 3 millimeter broad based disc bulge at L5-S1 with mild to moderate bilateral transforaminal narrowing and a 2 millimeter broad based disc bulge at L4-L5 with mild bilateral foraminal narrowing. According to a progress report dated 07-24-2015, the injured worker reported cervical spine pain rated 8 on a scale of 1-10 with bilateral upper extremity radicular pain. The provider noted that an MRI would be requested to rule out "I-D" as the injured worker had 18 chiropractic, 12 acupuncture and 21 physical therapy sessions with mild relief. Additional chiropractic care was denied. She also reported lumbar spine pain rated 8 with bilateral lower extremity radicular pain and numbness. Right shoulder pain was rated 9. Left knee pain was rated 8 with giving out noted. Medications were helpful and the injured worker was able to perform activities of daily living. Weaning had been tried and was unsuccessful. There was no functional change since the last visit. Review of systems was positive for sleep disturbance, depression, stress and anxiety. Physical examination demonstrated mild distress, difficulty rising from sitting, guarding of right upper extremity, antalgic gait and stiffness. Medication was helping with pain. She was taking medication as prescribed. There were no adverse effects.

There was an undated form attached to the progress report that listed the following findings: cervical and cervical-thoracic tenderness, spasm present, motor testing was 5 of 5 with shoulder, elbow flexion, wrist extension, wrist flexion, grip, finger flexion and finger extension. Cervical spine range of motion was 50 of 50 with flexion, 50 of 60 with extension, 50 of 80 with right rotation and 50 of 80 with left rotation. Diagnoses included cervical spine strain sprain rule out C6-7 radiculopathy, rule out I-D herniated nucleus pulposus, right shoulder sprain strain, RTC tendinitis, possible tear degenerative labral tear, lumbar spine sprain strain right greater than left sciatica, facet osteoarthritis, L5-S1 3 millimeter herniated nucleus pulposus, left knee "PH MMT, Plt LMT", gastritis due to meds, major depression, insomnia and diabetes mellitus and gastritis per other MD. Prescriptions were given for Norco 5-325 mg 1 by mouth twice a day #60 with no refills and "FMCC". Permanent and stationary date was 12-30-2014. Authorization requests dated 07-28-2015 were submitted for review. The requested services included magnetic resonance imaging of the cervical spine, Norco 5-325 mg twice a day #60 and Flurbi-Menthol-Caps-Camph cream. On 08-07-2015 Utilization Review non-certified the request for MRI of the cervical spine, topical cream Flurbi-Menthol-Caps-Camph cream and Norco 5-325 mg #60.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**MRI of the cervical spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Magnetic resonance imaging (MRI).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Magnetic resonance imaging (MRI).

**Decision rationale:** Per the ODG guidelines with regard to MRI of the lumbar spine: Not recommended except for indications list below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. 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, and recurrent disc herniation). (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria. MRI imaging studies are valuable when physiologic evidence indicates tissue insult or nerve impairment or potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back surgery. (Bigos, 1999) (Bey, 1998) (Volle, 2001) (Singh, 2001) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the

initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007) Indications for imaging--MRI (magnetic resonance imaging): Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present, Neck pain with radiculopathy if severe or progressive neurologic deficit, Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present, Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present, Chronic neck pain, radiographs show bone or disc margin destruction, Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal", Known cervical spine trauma: equivocal or positive plain films with neurological deficit, Upper back/thoracic spine trauma with neurological deficit. I respectfully disagree with the UR physician, per the medical records, the injured worker continues to complain of cervical spine pain rated 8/10 with bilateral upper extremity radicular pain. I respectfully disagree with the UR physician's assertion that there is no documentation of neurological signs. There is neuropathic referred radicular pain for greater than 3 months with non-revealing plain films. The request is medically necessary.

**Topical cream Flurbi-Menthol-Caps-Camph cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical Analgesics, compounded.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Capsaicin may have an indication for chronic lower back pain in this context. Per MTUS p 112 Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. Per MTUS with regard to Flurbiprofen (p 112), "(Biswal, 2006) these medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." The documentation contains no evidence of osteoarthritis or tendinitis. Flurbiprofen is not indicated. Regarding the use of multiple medications, MTUS p 60 states only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005) The recent AHRQ review of comparative effectiveness and

safety of analgesics for osteoarthritis concluded that each of the analgesics was associated with a unique set of benefits and risks, and no currently available analgesic was identified as offering a clear overall advantage compared with the others. Therefore, it would be optimal to trial each medication individually. The CA MTUS, ODG, National Guidelines Clearinghouse, and ACOEM provide no evidence-based recommendations regarding the topical application of menthol or camphor. It is the opinion of this IMR reviewer that a lack of endorsement, a lack of mention, inherently implies a lack of recommendation, or a status equivalent to "not recommended". Since several components are not medically indicated, then the overall product is not indicated per MTUS as outlined below. Note the statement on page 111: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request is not medically necessary.

**Norco 5/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ACOEM Chapter 6-Pain, Suffering, and the Restoration of Function, Preventing and Managing Chronic Pain, Official Disability Guidelines (ODG), Pain, Hydrocodone/Acetaminophen, Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**Decision rationale:** Per MTUS Chronic Pain Medical Treatment Guidelines p 78 regarding on-going management of opioids Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. These domains have been summarized as the 4 A's (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. Review of the available medical records reveals no documentation to support the medical necessity of norco nor any documentation addressing the '4 A's' domains, which is a recommended practice for the on-going management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. The medical records contained UDS dated 5/29/15 which was inconsistent for prescribed alprazolam, and negative for opiates. As MTUS recommends discontinuing opioids if there is no overall improvement in function, medical necessity cannot be affirmed, therefore is not medically necessary.