MAXIMUS Federal Services

Case Number:	CM15-0174555		
Date Assigned:	09/16/2015	Date of Injury:	04/01/2014
Decision Date:	10/19/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	09/04/2015

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
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 60 year old, female who sustained a work related injury on 4-1-14. The diagnoses have included cervical disc herniation without myelopathy, lumbar disc displacement with myelopathy, sciatica, medial meniscus tear of the right knee, thoracic strain-sprain, medial and lateral epicondylitis of the right elbow, tendinitis-bursitis of the right hand-wrist and right ankle strain-sprain. Treatments have included medicated cream, use of a right wrist brace and home exercises. Current medications include medicated cream. In the progress notes dated 8-3-15, the injured worker reports constant severe cervical spine pain described as aching, stabbing and sharp. She states the pain radiates into her shoulders. She complains of constant severe thoracic spine pain described as sharp and stabbing. She reports constant severe lumbar spine pain described as sharp. She reports lumbar spine pain radiates down her legs. She reports of frequent severe right elbow pain described as aching. She reports this pain radiates down her forearm. She reports constant severe pain in right wrist-hand pain described as sharp. She states she has numbness and tingling in the right hand and fingers. She reports constant severe pain in the right knee described as throbbing and swelling. She states the pain radiates into her calf and this knee occasionally gives out on her. She reports constant severe pain in her right ankle and foot described as dull and aching. She states she has swelling in this foot. On physical exam, she has +3 spasm and tenderness along the paraspinal muscles of the cervical, thoracic and lumbar spine. Shoulder depression test is positive in both shoulders. Straight leg raise test is positive in both legs. Sensation is decreased in L5 and S1 dermatomes on the right. She has +3 spasm and tenderness to the right lateral and epicondyles. Cozen's and reverse Cozen's tests are

positive on the right. She has +2 spasm and tenderness to the right anterior wrist, right posterior extensor tendons, right thenar eminence and right hypothenar eminence. Tinel's test is positive on the right. She has mild swelling in right knee. She has +2 spasm and tenderness to the right anterior joint line, vastus medialis and popliteal fossa. She has +4 spasm and tenderness to the right lateral malleolus. EMG-NCV studies dated 8-13-15 are normal. She is not working. The treatment plan includes refill of medicated cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow-up visit: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Shoulder Complaints 2004, and Elbow Complaints 2007, and Forearm, Wrist, and Hand Complaints 2004, and Low Back Complaints 2004, and Knee Complaints 2004, and Ankle and Foot Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): General Approach, Physical Examination, and Low Back Complaints 2004, Section(s): General Approach, Physical Examination, and Knee Complaints 2004, Section(s): General Approach, Physical Examination. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter/Office Visits Section.

Decision rationale: The MTUS Guidelines do not address office visits specifically for chronically injured workers. The MTUS Guidelines recommend frequent follow-up for the acutely injured worker when a release to modified, increased, or full activity is needed, or after appreciable healing or recovery can be expected, on average. Per the ODG, repeat office visits are determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. This request is for a follow-up visit with the treating physician, without specific treatment goals. As there is no stated reason for a follow-up visit, the request for follow-up visit is determined to not be medically necessary.

Compound medication: Lidocaine 6%, Gabapentin 10%, Ketoprofen 10%, 180gm with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: Topical analgesics are recommended by the MTUS Guidelines. Compounded topical analgesics that contain at least one drug or drug class that is not recommended is not recommended. Topical lidocaine is used primarily for neuropathic pain when trials of antidepressant and anticonvulsants have failed. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. Topical lidocaine in the formulation of a cream or lotion is not recommended. The MTUS Guidelines do not recommend the use of topical gabapentin as there is no peer-reviewed literature to support use. These guidelines report that topical ketoprofen is not FDA approved, and is therefore not recommended by these guidelines. As at least one of the medications on the requested compounded medication is not recommended by the established guidelines, the request for compound medication: Lidocaine 6%, Gabapentin 10%, Ketoprofen 10%, 180gm with 2 refills is determined to not be medically necessary.

Compound medication: Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5%, 180gm with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), Topical Analgesics.

Decision rationale: Topical analgesics are recommended by the MTUS Guidelines. Compounded topical analgesics that contain at least one drug or drug class that is not recommended is not recommended. Topical lidocaine is used primarily for neuropathic pain when trials of antidepressant and anticonvulsants have failed. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. Topical lidocaine in the formulation of a cream or lotion is not recommended. Topical NSAIDs, have been shown to be superior to placebo for 4-12 weeks for osteoarthritis of the knee. The injured worker's pain is not described as pain from osteoarthritis. Topical flurbiprofen is not an FDA approved formulation. The MTUS Guidelines state that there is no evidence for use of muscle relaxants, such as cyclobenzaprine or baclofen, as a topical product. As at least one of the medications on the requested compounded medication is not recommended by the established guidelines, the request for compound medication: Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5%, 180gm with 2 refills is determined to not be medically necessary.