

Case Number:	CM15-0037873		
Date Assigned:	04/16/2015	Date of Injury:	11/21/2014
Decision Date:	06/05/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	02/27/2015

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, Arizona
 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 23 year old male with an industrial injury dated November 21, 2014. The mechanism of injury was not provided. The injured worker diagnoses include cervical disc herniation without myelopathy, thoracic disc displacement without myelopathy, lumbar disc displacement without myelopathy, partial tear of rotator cuff tendon of the left shoulder, left hip sprain/strain, tear of medial meniscus of the left knee, cruciate ligament sprain of the left knee, and left ankle sprain/strain. He has been treated with 4 sessions of physical medicine and periodic follow up visits. Prior diagnostic studies included an MRI of the whole body, CT scan of the head and radiographic studies of the left shoulder. The prior therapy included physical therapy, medications, a TENS unit, a can and a rigid Neck brace. According to the progress note dated 01/19/2015, the injured worker reported constant severe pain in the cervical spine, lumbar spine, left shoulder, left hip, left knee, left ankle, and foot. Objective findings revealed spasm and tenderness to the cervical spine, thoracic spine, lumbar spine, left shoulder, left hip, left knee, left ankle, and foot. The treating physician prescribed topical compound containing Lidocaine 6%, Gabapentin 10%, Ketoprofen 10% 180gm with 2 refills, 1 prescription of topical compound containing Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5% 180gm with 2 refills, 1 work conditioning/hardening screening, 1 functional capacity evaluation, and Magnetic Resonance Imaging (MRI) of the lumbar spine, cervical spine and hip.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of topical compound containing Lidocaine 6%, Gabapentin 10%, Ketoprofen 10% 180gm with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Ketoprofen, Lidocaine, Gabapentin Page(s): 111, 112, 113.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is not currently FDA approved for a topical application "Gabapentin is not recommended." There is no peer-reviewed literature to support use. Other anti-epilepsy drugs: There is no evidence for use of any other anti-epilepsy drug as a topical product. The guidelines indicate that topical lidocaine (Lidoderm) may be 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). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation that the injured worker had a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation indicating a necessity for 2 topical medications with NSAIDs and muscle relaxants. There was a lack of documented rationale for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency and the body part to be treated. Given the above, the request for 1 prescription of topical compound containing Lidocaine 6%, Gabapentin 10%, Ketoprofen 10% 180gm with 2 refills is not medically necessary.

1 prescription of topical compound containing Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5% 180gm with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Topical Analgesics, Lidocaine, Baclofen, Flurbiprofen Page(s): 41, 111, 112, 113, 72.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no peer-

reviewed literature to support the use of topical baclofen. The guidelines do not recommend the topical use of Cyclobenzaprine or Baclofen as a topical muscle relaxant, as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine to other agents is not recommended. The guidelines indicate that topical lidocaine (Lidoderm) may be 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). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Regarding Topical Flurbiprofen, FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine - National Institute of Health (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration. The clinical documentation submitted for review failed to provide documentation that the injured worker had a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation indicating a necessity for two topical medications with NSAIDs and muscle relaxants. There was a lack of documented rationale for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for 1 prescription of topical compound containing Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5% 180gm with 2 refills is not medically necessary.

1 work conditioning/hardening screening: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG Physical Medicine Guidelines Work Conditioning.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 125.

Decision rationale: The California MTUS Guidelines indicate that the criteria for entering into a work hardening program include the presence of work related musculoskeletal conditions with functional limitation precluding ability to safely achieve current job demands, which are at a medium or higher demand level. A Functional Capacity Evaluation may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis. There should be documentation of an adequate trial of physical therapy with improvement followed by a plateau, but no likelihood that the patient would benefit from continued therapy and they should not be a candidate for surgery or other treatments. There should be documentation of a defined return to work goal and a documented specific job to return to that had job demands that exceed the patient's abilities and the patient must be able to benefit from functional and psychological interventions. As such, there should be documentation of a psychological examination. Per the referenced guidelines work condition is recommended for 10 visits over 8 weeks. The clinical documentation submitted for review indicated the request was made for a work hardening screening to see if the injured worker was a candidate for the work hardening program. However, there was a lack of documentation indicating the injured worker had an adequate trial of physical therapy with improvement by a plateau, with no likelihood the injured worker would benefit from continued therapy, and the documentation the

injured worker was not a candidate for surgery or other treatments. There was a lack of documentation that the injured worker's specific job demands exceeded the injured worker's abilities. Additionally, the request as submitted was for both work conditioning and work hardening. As such, and without clarification, the request for 1 work conditioning/hardening screening is not medically necessary.

1 functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7 [Independent Medical Examinations and Consultations].

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, FCE.

Decision rationale: The American College of Occupational and Environmental Medicine guidelines indicate there is a functional assessment tool available and that is a Functional Capacity Evaluation, however, it does not address the criteria. As such, secondary guidelines were sought. The Official Disability Guidelines indicates that a Functional Capacity Evaluation is appropriate when a worker has had prior unsuccessful attempts to return to work. There was a lack of documentation indicating the injured worker had a failure to return to work. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for 1 functional capacity evaluation is not medically necessary.

3D MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-8. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic).

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

Decision rationale: The Official Disability Guidelines indicate a repeat MRI is appropriate when there are objective findings suggestive of a significant pathology and a significant change in symptoms. The clinical documentation submitted for review indicates the injured worker had previously undergone a full body MRI. There was a lack of documented rationale for a 3D image and documentation of a significant change in symptoms or findings suggestive of a significant pathology. Given the above, the request for 3D MRI of the cervical spine is not medically necessary.

3D MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRI.

Decision rationale: The Official Disability Guidelines indicate a repeat MRI is appropriate when there are objective findings suggestive of a significant pathology and a significant change in symptoms. The clinical documentation submitted for review indicates the injured worker had previously undergone a full body MRI. There was a lack of documented rationale for a 3D image and documentation of a significant change in symptoms or findings suggestive of a significant pathology. Given the above, the request for 3D MRI of the lumbar spine is not medically necessary.

3D MRI of the left hip: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, MRI (magnetic resonance imaging).

Decision rationale: The Official Disability Guidelines indicate an MRI is appropriate for avascular necrosis of the hip and osteonecrosis. The documentation indicated the injured worker had previously undergone a full body MRI. There was a lack of documented rationale for a 3D study. Given the above, the request for a 3D MRI of the left hip is not medically necessary.