MAXIMUS Federal Services

Case Number:	CM15-0049307		
Date Assigned:	04/15/2015	Date of Injury:	03/25/2014
Decision Date:	05/29/2015	UR Denial Date:	02/18/2015
Priority:	Standard	Application Received:	03/16/2015

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, Washington
Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 36-year-old female who sustained an industrial injury on 03/25/2014. The injured worker's diagnoses, and/or impressions, include: low back pain with muscle spasm, lumbosacral radiculitis and arthropathy of the lumbar facets; lumbar spondylosis; lumbar disc degeneration; sciatica; left elbow contusion with left elbow joint pain; left radiohumero sprain/strain with ulnar neuritis; left shoulder rotator cuff sprain and joint pain; left carpal tunnel sprain/strain with wrist joint pain. No current diagnostic studies were provided. The injured worker's treatments have included 2 translaminar lumbosacral epidural steroid injections (last on 10/17/2014); physical therapy; occupational therapy; work restrictions; medication management. The progress note dated 02/04/2015 noted complaints of radiating lumbar spine pain; left wrist and hand pain; radiating left elbow pain; and left shoulder pain. On physical examination of the lumbar spine, there was noted tenderness to the bilateral lumbar paraspinal muscles from L1-5 with evidence of +3 spasms. Range of motion was minimally restricted and painful. Straight leg raise on the left was positive, Kemp's test was positive bilaterally, Yeoman's was positive bilaterally, and Braggard's test was positive on the left. Lumbar dermatomes were equal bilateral to light touch and lumbar myotomes were within normal limits bilaterally. Examination of the shoulder demonstrated tenderness to the bilateral upper shoulder muscles and evidence of +2 spasm, range of motion of the left shoulder was within normal limits, but painful during extension and adduction. Supraspinatus test was positive on the left. Examination of elbow demonstrated tenderness as well as 2+ spasm. Range of motion was restricted and painful during flexion and pronation. Cozen's test was positive on the left. Examination of the wrist and hand

demonstrated tenderness to the left anterior wrist and evidence of 2+ spasms. Range of motion was minimally restricted, but painful in all ranges. A bracelet test was positive on the left. The physician's requests for treatment lidocaine topical compound with refill; flurbiprofen topical compound with refill; refill of Ultram; lumbosacral orthosis; nerve conduction velocity studies of the lower extremities; electromyography of the lower extremity; and Functional Capacity Evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

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

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines continue to state that any compounded product that contains at least 1 drug (or drug class) that is not recommended the entire product is not recommended. Furthermore, the guidelines continue to state that topical lidocaine, in the formulation of dermal patch (Lidoderm) is currently the only FDA-approved formulation of topical lidocaine for treatment of neuropathic pain. The guidelines also state gabapentin in the form of a topical analgesic is not currently recommended, as there is no peer reviewed literature to support its use. Furthermore, the guidelines state that Ketoprofen is not FDA-approved for topical application due to extremely high incidents of photo contact dermatitis associated with its use. There was a lack of evidence within the documentation that the injured worker has tried and failed treatment with antidepressants and anticonvulsants prior to the recommendation for topical analgesics. Additionally, this compounded medication contains drug formulations that are not currently approved by the FDA or recommended by the treatment guidelines. Therefore, the request for lidocaine 6%, gabapentin 10%, Ketoprofen 10% 180 gm with 2 refills is not medically necessary.

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

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants

have failed and any compounded product that contains at least 1 drug (or drug class) that is not recommended the entire product is not recommended. The guidelines continue by stating that nonsteroidal anti-inflammatory agents in the form of topical medications may be recommended for osteoarthritis or tendonitis, in particular, that of the knee or elbow or other joints amenable to topical treatment for short term use (4 to 12 weeks); however, it is not recommended for treatment of osteoarthritis of the spine, hip, or shoulder, or for the treatment of neuropathic pain. The guidelines also state that the only currently FDA-approved nonsteroidal anti-inflammatory agent is Voltaren gel 1%. Furthermore, the guidelines state that muscle relaxants in the form of topical medication are not currently recommended for use as there is no evidence to support their use. Moreover, the guidelines state that baclofen in the form of a topical medication is not currently recommended, as there is no peer reviewed literature to support its use and lidocaine in the formulation of a dermal patch (Lidoderm) is FDA-approved for neuropathic pain; however, there is no other commercially approved topical formulation of lidocaine indicated for use. There is a lack of evidence within the documentation provided that the injured worker had tried and failed treatment with antidepressants and anticonvulsants prior to consideration of this compounded medication. Additionally, this compounded medication contains drug formulations that are not currently approved by the FDA or recommended by the treatment guidelines. Therefore, the request for flurbiprofen 15%, cyclobenzaprine 2%, baclofen 2%, lidocaine 5% 180 gm with 2 refills is not medically necessary.

2 refills of Ultram 50mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-80, 93-94, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram), Opioids, specific drug list Page(s): 113, 93-94.

Decision rationale: According to the California MTUS Guidelines, tramadol is a centrally acting sympathetic opioid analgesic that is not recommended as a first line oral analgesic; however, it may be recommended for treatment of moderate to severe pain. The documentation indicates that the injured worker has previously been prescribed this medication; however, there is no documentation provided in regard to the injured worker's measurable therapeutic benefit from the use of this medication. Additionally, it is unclear whether the injured worker has tried and failed first line medication prior to consideration of this medication. Therefore, the request for 2 refills of Ultram 50 mg #100 is not medically necessary.

Lumbosacral orthosis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 297-298. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar supports.

Decision rationale: According to the American College of Occupational and Environmental Medicine Guidelines, there is no evidence for effectiveness of lumbar supports for back pain. Additionally, the Official Disability Guidelines state that lumbar supports may be recommended for the treatment of compression fractures and specific treatment of spondylolisthesis, and/or documented instability. There is a lack of evidence within the documentation that the injured worker has a compression fracture, spondylolisthesis, or documented instability that would benefit from the use of lumbosacral orthosis. Therefore, the request for lumbosacral orthosis is not medically necessary.

NCV testing of the left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Nerve conduction studies (NCS).

Decision rationale: The California MTUS/ACOEM Guidelines do not specifically address this request. However, the Official Disability Guidelines state that nerve conduction studies are not currently recommended as there is minimal justification for performing nerve conduction studies on a patient presumed to have symptoms on the basis of radiculopathy. The documentation provided indicates the injured worker was noted to have normal motor and sensory examination. Additionally, this request is not currently recommended by treatment guidelines. Therefore, the request for NCV testing of the lower left extremity is not medically necessary.

EMG testing of the left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines state that electromyography may be recommended to clarify nerve root dysfunction. This request remains unclear, as there is a lack of documentation that the injured worker has neurological deficits that require clarification; the documentation provided indicates the injured worker had normal motor and sensory examination. Therefore, the request for EMG testing of the left lower extremity is not medically necessary.

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 OMPG Second Edition (2004), Chapter 7, page 127 - Consultation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional capacity evaluation (FCE).

Decision rationale: The California MTUS/ACOEM Guidelines do not specifically address this request; however, the Official Disability Guidelines state that Functional Capacity Evaluations may be recommended prior to admission to a work hardening program or if case management is hampered by complex issues, such as prior unsuccessful return to work attempts; conflicting medical reporting on precautions and/or fitness for modified job; and/or injuries that require detailed exploration of the worker's abilities and the patient is either close or at MMI and/or additional/secondary conditions need to be clarified. The Official Disability Guidelines continue by stating that Functional Capacity Evaluations are not recommended to determine a worker's effort or compliance and is not recommended for routine use as part of occupational rehab or screening, or for generic assessment. It was noted in the documentation provided that the Functional Capacity Evaluation is being recommended as a functional improvement measure; however, the Official Disability Guidelines state that Functional Capacity Evaluation is not intended to be a generic assessment to determine the patient's functional level. Additionally, it remains unclear whether the injured worker is close or at MMI. Furthermore, there is no documentation that the injured worker has had tried and failed previous return to work attempts. Therefore, the request for Functional Capacity Evaluation is not medically necessary.