

Case Number:	CM13-0013879		
Date Assigned:	03/10/2014	Date of Injury:	08/28/2007
Decision Date:	07/15/2014	UR Denial Date:	08/08/2013
Priority:	Standard	Application Received:	08/20/2013

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. The expert reviewer is Board Certified in Internal Medicine, and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 64 year old male who was injured on 01/01/2004. The mechanism of injury is unknown. Prior treatment history has included aquatic therapy for 3 months which provided him with 50% symptomatic relief and helped his range of motion. Medical therapy has included Norco 10/325mg, Flexeril 10mg, Anaprox DS and Flurbiprofen 20% gel. PR2 dated 12/09/2013 documented the patient to have complaints of frequent neck pain, rated 7/10 with radiation to the bilateral upper extremities and frequent low back pain rated 7/10 with radiation to the bilateral lower extremities. Objective findings on examination of the lumbar spine revealed decreased range of motion; straight leg raise is positive on the right; lower extremity motor strength is 5/5 bilaterally in the longus muscle groups except for weakness in the bilateral extensor hallucis longus and gastrocnemius at 4/5; sensory examination is intact bilaterally in the lower extremities. There are lumbar paraspinal spasms and tenderness which is unchanged since PR2 05/31/2013. The patient was diagnosed with status post posterior fusion and decompression at L4-S1 on 05/07/2012 and vision dysfunction secondary to decreased cranial nerve II. QME Report dated 07/12/2013 indicated the patient uses a walker as well as a cane post-operatively. He started physical therapy modalities and he started pool therapy. The patient presented with complaints of pain and stiffness of his neck, pain in his low back, although he states it has improved since surgery. He states he is able to perform chores around his residence with discomfort and he does these slowly. He states at times he uses a walker for ambulation and at times he can walk for very short distances and slowly without a cane. On physical examination, he is using a rolling walker and wearing a lumbar support. He is able to walk short distances, slowly, without use of a walker. The treating provider has requested Norco 10/325mg # 120, Flur20gel #1, ad K10/Keta 20 gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF NORCO 10/325MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009), Opioids For Chronic Pain, Opioids, Criteria For Use, On Going Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78-80, 91-97.

Decision rationale: Per California MTUS Guidelines, short-acting opioids such as Norco are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. According to the guidelines, ongoing pain management with opioids requires ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioids; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, the increased level of function, or improved quality of life. Opioid should be continued if: the patient has returned to work or if the patient has improved functioning and pain. The medical records indicate the patient has been utilizing Norco for an extended period of time, however there does not appear to be documentation establishing clinically significant pain relief leading to improved function as a result of Norco. The guidelines document that without demonstrated demonstration of improved pain and function, continued opioid use is not recommended, and should be discontinued. The medication should be weaned to off. The medical necessity for the requested item has not been established. The requested item is not medically necessary.

PRESCRIPTION OF TOPICAL COMPOUND FLUR20 GEL #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009), Topical Analgesics.

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

Decision rationale: There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, y agonists,

prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended According to the guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines state there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Only FDA-approved products are currently recommended, and there is no recommendation in the evidence based guidelines for Flurbiprofen in a topical formulation. Therefore, the medical necessity of this product has not been established.

PRESCRIPTION OF TOPICAL COMPOUND K10/ KETA20 GEL #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009), Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, gamma agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended This product contains Ketoprofen and Ketamine. According to the guidelines, Ketamine is currently under study. It is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. The medical records do not substantiate neuropathic pain with exhaustion of appropriate first- and second-line therapies. Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

PRESCRIPTION OF TOPICAL COMPOUND G10/C10/C0.0375 GEL #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009), Topical Analgesics.

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

Decision rationale: There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of

systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, gamma agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. This product contains Gabapentin, Cyclobenzaprine, and Capsaicin. According to the guidelines, muscle relaxants, such as cyclobenzaprine, are not recommended in topical formulation. Additionally, the guidelines state Gabapentin is not recommended. There is no peer-reviewed literature to support use. Furthermore, the medical records do not establish capsaicin is appropriate and medically necessary, as it is unsubstantiated that the patient is intolerant to first-line therapies. Medical necessity for the requested item has not been established. The requested item is not medically necessary

1 ELECTRIC SCOOTER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009), Power Mobility Devices (PMDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

Decision rationale: The guideline state power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. The 12/19/2013 medical report does not document a current functional mobility deficit. In addition, the 7/12/2013 QME report documented the patient had use of a cane and a rolling walker. The medical records do not establish a power scooter is essential and medically necessary for this patient.

8 AQUATIC/POOL THERAPY SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009), Aquatic Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

Decision rationale: According to the guidelines, aquatic therapy is recommended as an optional form of exercise therapy, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. The medical records demonstrate this patient has undergone 3 months of aquatic therapy. The medical records do not

substantiate significant gains as a result of aquatic therapy. Furthermore, significant functional limitations are also not apparent. He is not morbidly obese. It is not indicated that the patient would obtain any significant benefit with further aquatic therapy. At this juncture, the patient's focus should be on utilization of a self-directed home exercise and activity program, which would not require access to aquatic facilities. The medical records do not establish aquatic therapy is medically necessary at this time.