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| Case Number: | CM13-0034642 | | |
| Date Assigned: | 12/11/2013 | Date of Injury: | 08/01/2012 |
| Decision Date: | 02/11/2014 | UR Denial Date: | 09/16/2013 |
| Priority: | Standard | Application Received: | 10/15/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and is licensed to practice in District of Columbia. 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 physician 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.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

██████ was a 49 year old woman who was having low back, left hip and bilateral groin pain. Her date of injury was 08/1/12. Her mechanism of injury was lifting heavy weight throughout the day at work. Her MRI in 2012 showed mild disc disease at L3-4 and L5-S1 without significant spinal stenosis or lumbar foraminal narrowing. Her evaluation included an MRI that showed tendinosis and small partial thickness tear of the gluteus medius fibers bilaterally. A repeat MRI of lumbar spine showed L4-5 facet arthropathy and small facet effusions, mild central canal spinal stenosis, broad disc L3-4 protrusion and her treatment initially included medications, injections and radiofrequency. In July 2013. She was seen by the treating provider and was found to have 7-8/10 pain in low back. She was having insomnia and depression. She was found to have tenderness in low back. On August 29, 2013 she was seen by the primary treating provider for persistent pain. She also had reported feeling a pop when she got up and looked something up. Her pain was 7-8/10 in intensity. Her treatment included Physical therapy and Medrox patch and Terocin lotion topically. Her diagnoses included lumbar condition with facet inflammation and left sided radiculopathy left hip strain and sprain, depression, bilateral groin sprain or strain and urinary incontinence. In August 20, 2013, she was seen by the treating provider for ongoing discomfort of her low back. She was reporting an aching, dull, stabbing, throbbing discomfort that was moderate to severe. She was noted to be taking Norco and Valium. There was tenderness to palpation of lumbar paraspinous region with loss of flexion and extension. Her diagnosis included lumbar spine sprain and strain with multi level spondylosis. She saw her treating provider in October 2013 and was noted to have soreness in bilateral groins with walking. Low back pain was noted to be constant at 5/10 in intensity. She also reported on and off vaginal pain. She had tendernes

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times a week for 4 weeks to the lumbar/left hip: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98, Postsurgical Treatment Guidelines.

Decision rationale: According to MTUS, Physical therapy is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s).. According to ODG, patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). In this case, it is not clear whether when prior physical therapy treatment was done. Also it is not clear what the outcomes were. She did have an acute worsening of her chronic pain due to the pop that she felt which will support the need for physical therapy. But according to the six-visit clinical trial guidelines per ODG, only a 6 visit referral to PT is medically necessary. Since the requests can only be certified or non certified and since they cannot be modified, the medical necessity for 12 sessions of PT is not met.

Medrox patch #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 112.

Decision rationale: Medrox is a topical analgesic containing 0.0375% Capsaicin, 5% methyl salicylate and 5% menthol. According to MTUS, topical analgesics are recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate (Colombo, 2006). Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local

anesthetics, antidepressants, glutamate receptor antagonists, $\hat{1}\pm$ -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, $\hat{1}^3$ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain and is recommended for chronic pain. Topical Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. 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. In this particular case, higher dose of Capsaicin (0.0375%) exceeds the guideline recommendations and hence Medrox doesn't meet the medical necessity guidelines per MTUS.

Terocin lotion 4oz: Upheld

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

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

Decision rationale: According to MTUS topical analgesics are recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate (Colombo, 2006). Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, $\hat{1}\pm$ -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, $\hat{1}^3$ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Terocin is a compounded formulation of Methyl Salicylate 25%, Capsaicin 0.025%, Menthol 10% and Lidocaine 2.5%. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain and is recommended for chronic pain. Topical Lidocaine is 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). In this case, the pain is due to lumbar disc disease and lumbar sprain or strain. There is no

documentation of neuropathic pain. Hence a compounded product with lidocaine is not meeting the guidelines per MTUS.