

Case Number:	CM13-0048057		
Date Assigned:	12/27/2013	Date of Injury:	09/22/2011
Decision Date:	06/30/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	11/04/2013

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 Occupational Medicine, and is licensed to practice in California. 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 41-year-old who has submitted a claim for lumbar herniated nucleus pulposus, lumbar radiculopathy, myospasm and myofascial trigger points in the cervical and lumbosacral regions, internal derangement of the right shoulder, cervicgia, and depression associated with an industrial injury date of September 22, 2011. Medical records from 2012-2013 were reviewed, the latest of which dated May 22, 2013 revealed that the patient presents with low back pain rated 8/10. The pain increases with activities involving bending and lifting. It radiates to the right lower extremity. He complains of neck pain rated 7/10 without radiation, and right shoulder pain rated 3/10. On physical examination, there is positive straight leg raising test on the right. There is limitation in range of motion flexion to approximately 80 degrees, with pain. Treatment to date has included right shoulder steroid injection (September of 2012), right L5-S1 transforaminal epidural steroid injections (June 14, 2013), TENS, physical therapy, chiropractic therapy, and medications which include naproxen, tramadol gabapentin, Ambien, Ativan, Wellbutrin SR, and compounded creams (Flurbiprofen 25%/lidocaine 5% and Tramadol 15%/Dextro 10%/Cap 0.025). Utilization review from October 17, 2013 denied the request for physical therapy 2 times a week for 3 week for cervical spine & right shoulder because the patient has had extensive physical therapy and there is no documentation of subjective or objective benefit from it; denied the request for Flurbiprofen 25%/lidocaine 5% because the patient is on oral NSAIDs and guidelines do not recommend compound topical; and denied the request for Tramadol 15%/Dextro 10%, Cap 0.025% because it contains non-recommended ingredients and the patient is on oral tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSIO THERAPY 2 TIMES A WEEK FOR 3 WEEKS FOR THE CERVICAL SPINE:

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In addition, guidelines allow for fading of treatment frequency from up to three visits per week to one or less plus active self-directed home physical medicine. In this case, additional physical therapy was requested; however, the rationale is unknown due to lack of documentation. The patient had previous physical therapy sessions but there was no documentation of functional improvement. The medical necessity has not been established due to lack of information. The request for physical therapy for the cervical spine and right shoulder, twice weekly for three weeks, is not medically necessary or appropriate.

FLURBIPROFEN 25%/LIDOCAINE5%: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, ,

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, the use of topical creams are only optional and is still largely experimental in use with few randomized controlled trials to determine efficacy or safety. Most of these agents are compounded. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The guidelines state that there is little evidence to support the use of topical NSAIDs (non-Steroidal anti-inflammatory drugs, such as flubiprofen) for treatment of osteoarthritis of the spine, hip or shoulder, and there is no evidence to support the use for neuropathic pain. Regarding the Lidocaine component, guidelines state that topical formulations of lidocaine (whether creams, lotions or gels) are not indicated for neuropathic or non-neuropathic pain complaints. In this case, flurbiprofen 25%/lidocaine 5% cream was requested; however, the rationale is unknown due to lack of documentation. In the recent clinical evaluation, there was no mention whether the patient responded to or is intolerant to other treatments. The requested medication contains active components that are not recommended for

topical use. The request for Flurbiprofen 25%/Lidocaine5% is not medically necessary or appropriate.

TRAMADOL 15%/DEXTRO 10%/CAP 0.025%: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 28, 111.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, use of topical creams are only optional and is still largely experimental in use with few randomized controlled trials to determine efficacy or safety. Most of these agents are compounded. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Regarding the Capsaicin component, the Chronic Pain Medical Treatment Guidelines identify on page 28 that topical Capsaicin is only recommended as an option when there was failure to respond or intolerance to other treatments; with the 0.025% formulation indicated for osteoarthritis. Guidelines do not recommend the use of topical tramadol and dextromethorphan. In this case, Tramadol 15%/Dextro 10%/Cap 0.025% cream was requested; however, the rationale is unknown due to lack of documentation. In the recent clinical evaluation, there was no mention whether the patient responded to or is intolerant to other treatments. The requested medication contains active components that are not recommended for topical use. The request for Tramadol 15%/Dextro 10%/Cap 0.025% is not medically necessary or appropriate.

PHYSIO THERAPY 2 TIMES A WEEK FOR 3 WEEKS FOR THE RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In addition, guidelines allow for fading of treatment frequency from up to three visits per week to one or less plus active self-directed home physical medicine. In this case, additional physical therapy was requested; however, the rationale is unknown due to lack of documentation. The patient had previous physical therapy sessions but there was no documentation of functional improvement. The medical necessity has not been established due to lack of information. The

request for physical therapy for the cervical spine and right shoulder, twice weekly for three weeks, is not medically necessary or appropriate.