

Case Number:	CM13-0054374		
Date Assigned:	12/30/2013	Date of Injury:	08/15/2010
Decision Date:	03/17/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	11/19/2013

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 Physical Medicine and Rehabilitation has a subspecialty in Pain Management 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 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. 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:

This is a female patient with a date of injury of 8/15/10. A utilization review determination dated 11/7/13 recommends non-certification of Methoderm gel, Flurbiprofen gel, and Anaprox. A urine drug test was noted to be withdrawn by the treating provider. A progress report dated 10/7/13 identifies subjective complaints including frequent low back pain with radiation to the bilateral lower extremities with numbness and tingling, frequent right shoulder pain, and occasional left shoulder pain. Current medications include Medrox patches, topical creams, Naprosyn, and Zanaflex. Objective examination findings identify right shoulder decreased ROM, severe pain with elevation, tenderness to palpation over the lumbar spine, positive SLR bilaterally, and weakness in the right extensor hallucis longus and left peroneus longus 4/5. Treatment plan recommends Methoderm Gel, Flurbiprofen gel, Anaprox, Flexeril, and a Urine Drug Test.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methoderm Gel 120mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112 of 127.

Decision rationale: Regarding the request for Methoderm gel, Chronic Pain Medical Treatment Guidelines notes that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Within the documentation available for review, there is no documentation of the above. Additionally, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the currently requested Methoderm gel is not medically necessary.

Flurbiprofen Gel 120mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Regarding the request for Flurbiprofen gel, Chronic Pain Medical Treatment Guidelines notes that topical NSAIDs (non-steroidal anti-inflammatory drugs) are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Within the documentation available for review, there is no documentation of the above. Additionally, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the currently requested Flurbiprofen Gel is not medically necessary.

Anaprox DS 550mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Regarding the request for Anaprox, Chronic Pain Medical Treatment Guidelines states that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that NSAIDs (non-steroidal anti-inflammatory drugs) are providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale) and objective functional improvement. In the absence of such documentation, the currently requested Anaprox is not medically necessary.

Flexeril 10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Regarding the request for Flexeril, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Flexeril. Additionally, it does not appear that this sedating muscle relaxant is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Flexeril is not medically necessary.

Urine Drug Test: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79 and 99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter Urine Drug Testing

Decision rationale: Regarding the request for a urine drug test, Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. Official Disability Guidelines (ODG) recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, it appears that the patient is not currently utilizing opioids or any other drugs of potential abuse. Furthermore, there is no documentation of current risk stratification and a rationale for the current frequency of testing. In light of the above issues, the currently requested urine drug screen is not medically necessary