

Case Number:	CM14-0000664		
Date Assigned:	01/17/2014	Date of Injury:	01/15/2013
Decision Date:	06/06/2014	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	01/02/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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:

This patient is a 48-year-old male with a date of injury of 01/15/2013. The listed diagnoses per [REDACTED] are: L4-L5 and L5-S1 disk herniation with right-sided radiculopathy, Mild right lower extremity foot drop, and Mild left shoulder impingement. According to the report from 11/06/2013 by [REDACTED], the patient presents with severe low back pain rated as 9/10 on a daily basis. The pain radiates down to the right greater than left lower extremity with constant numbness and tingling. Examination of the lumbar spine revealed difficulty with toe and heel walk. There is positive straight leg raise and sciatic stretch on the right. There is decreased sensation at L5-S1 right greater than left. There is tenderness to palpation over the lumbar spine with significantly reduced range of motion. Review of report from 10/23/2013 showed patient's medication was "helping to relieve the pain." Treater is requesting Norco 10/325 mg #60, Cyclobenzaprine 7.5 mg #60, Fluriflex cream, and TGICE cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 NORCO 10/325MG, 1 EVERY 6 HOURS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications For Chronic Pain, Page(s): 60, 61.

Decision rationale: This patient presents with severe low back pain that radiates down to the lower extremities. The patient is requesting a refill of Norco 10/325 mg #60. page 78 of Chronic Pain Medical Treatment Guidelines requires "Pain Assessment" that should include, "current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." Furthermore, "The 4 A's for ongoing monitoring" are required that include analgesia, ADL's, adverse side effects and aberrant drug-seeking behavior. This patient has been taking Norco since 06/14/2013. Review of reports from 08/09/2013 to 11/06/2013 does not show "pain assessment," functional improvement in terms of ADL's or change in work status as required by Chronic Pain Medical Treatment Guidelines. Given the lack of sufficient documentation, the patient should slowly be weaned off Norco as outlined by Chronic Pain Medical Treatment Guidelines. The requested Norco 10/325mg #60 is not medically necessary.

60 CYCLOBENZAPRINE 7.5MG, 1 EVERY BEDTIME OR 1 EVERY 12 HOURS AS NEEDED: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amri, Fexmid) Page(s): 64.

Decision rationale: This patient presents with severe low back pain that radiates down to the lower extremities. The patient is requesting Cyclobenzaprine 7.5 mg #60. The Chronic Pain Medical Treatment guidelines, page 64, states "Cyclobenzaprine is recommended for short course of therapy. Limited mixed evidence does not allow for recommendation for chronic use." In this case, the patient has been taking Cyclobenzaprine since 08/09/2013. Chronic Pain Medical Treatment Guidelines does not recommend long-term use of muscle relaxants and recommends using 3 to 4 days of acute spasm and no more than 2 to 3 weeks. The requested Cyclobenzaprine #60 is not medically necessary.

FLURIFLEX: FLURBIPROFEN/CYCLOBENZAPRINE 15%/10% CREAM 180GM, APPLY TO AFFECTED AREA TWICE DAILY: Upheld

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

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

Decision rationale: This patient presents with severe low back pain that radiates down to the lower extremities. The treater is requesting Fluriflex cream. Fluriflex cream includes Flurbiprofen and Cyclobenzaprine. The Chronic Pain Medical Treatment Guidelines p 111 has

the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." For Flurbiprofen, Chronic Pain Medical Treatment Guidelines states, "the efficacy in clinical trials for this treatment modality has been inconsistent, and most studies are small and of short duration. Topical NSAIDs (non-steroidal anti-inflammatory drugs) had been shown in the meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. Indications for use are osteoarthritis and tendinitis (in particular, that of the knee and elbow) or other joints that are amendable to topical treatment. In this case, the patient does not meet the indication for the topical medication as he does not present with any osteoarthritis or tendonitis symptoms. Furthermore, Cyclobenzaprine is a muscle relaxant and is not recommended for any topical formulation. The requested Fluriflex cream is not medically necessary.

TGICE (TRAMADOL 8%/GABAPENTIN 10%/MENTHOL 2%/ CAMPHOR 2%) CREAM 180GM, APPLY TO AFFECTED AREA TWICE DAILY: Upheld

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

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

Decision rationale: This patient presents with severe low back pain that radiates down to the lower extremities. The treater is requesting TGICE which includes Tramadol, Gabapentin, Menthol, and Camphor. The Chronic Pain Medical Treatment Guidelines page 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." Chronic Pain Medical Treatment Guidelines further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." Gabapentin is not recommended as a topical formulation. Therefore, the entire compounded formulation is not medically necessary.