

Case Number:	CM14-0100833		
Date Assigned:	07/30/2014	Date of Injury:	01/15/1998
Decision Date:	09/09/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	06/30/2014

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:

The patient is a 65-year-old female with date of injury of 01/15/1998. The listed diagnoses per [REDACTED] dated 01/17/2014 are: 1. Joint stiffness NEC - left leg. 2. Cervical sprain. 3. Lumbar sprain. 4. Right knee pain, status post arthroplasty. 5. Right knee pain. 6. Status post revision total knee arthroplasty. 7. Obesity. According to this report, the patient complains of moderate to severe low back and right lower extremity pain. The pain is a throbbing and aching in quality in both the lumbar spine and the right knee. She has intermittent moderate stabbing pain in the left knee. She rates the severity at 6/10 on the pain scale for the left knee and 4/10 on the right knee. There is pain with ambulation. The pain does not radiate. The physical therapy examination shows there is spasm on the lumbar spine during range of motion. Sensory testing with pinwheel is normal except for decreased sensation in the right thigh. Motor examination by manual muscle test is normal except for weakness in the right knee flexion and extension. Circulation is normal in the upper extremities. Some edema is noted in the bilateral lower extremities. There is tenderness present in the middle aspect of the bilateral knees. Drawer's test is positive on the right. The utilization review denied the request on 06/13/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluriflex cream 15/10% 240 gm: 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): 111.

Decision rationale: This patient presents with chronic low back pain and right lower extremity pain. The treater is requesting Fluriflex cream 15/10% 240 mg. The MTUS Guidelines page 111 on topical analgesics states that it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS also states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Fluriflex cream is a combination of Flurbiprofen 15% and Cyclobenzaprine 10%. In this case, Cyclobenzaprine is not recommended as a topical compound. Therefore, this request is not medically necessary.

Tram/ Gab/Menthol/ Camph/ caps TG Hot cream 0.05% 240 gm: 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): 111.

Decision rationale: This patient presents with chronic low back and right lower extremity pain. The treater is requesting TGHot cream 0.05% 240 mg. The MTUS Guidelines page 111 on topical analgesics states that it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for a neuropathic when trials of antidepressants and anticonvulsants have failed. MTUS further states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." TGHot cream is a combination of Tramadol/Gabapentin/Menthol/Camphor/Capsaicin. In this case, both Tramadol and Gabapentin compounds are not recommended in topical formulation. Therefore, this request is not medically necessary.

Hydrocodone APAP 10/325mg #60 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: This patient presents with chronic low back and right lower extremity pain. The treater is requesting Hydrocodone/APAP 10/325 mg, quantity #60 with 3 refills. For chronic opiate use, the MTUS Guidelines require specific documentations regarding pain and

function. Page 78 of MTUS requires "pain assessment" that requires "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, how long pain relief last." Furthermore, "the 4 A's for ongoing monitoring" are required which includes: analgesia, ADLs, adverse side effects, and aberrant drug-seeking behavior. The records show that the patient has been taking Hydrocodone/APAP since January 2014. The report dated 01/17/2014 notes medication efficacy stating, "Norco has been effective because it allows the patient to perform some activities of daily living. The medication is helping provide relief with the patient's moderate to severe pain." In the same report, the treater notes UDS (urine drug screen) dated 10/21/2013 that showed inconsistent results. Another UDS dated 01/23/2014 showed inconsistent results with medication regimen. None of the 74 pages of records show that the treater has done anything to address the patient's inconsistent UDS results. The treater continued to prescribe Hydrocodone/APAP following the patient's 2013 UDS showing inconsistent results. Given that, the treater has not addressed the patient's inconsistent urine drug screen. Therefore, the request for Hydrocodone/APAP 10/325mg #60 with 3 refills is not medically necessary.

Colace 100 mg #60 with 3 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain, Opioids, Criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Initiating Therapy Page(s): 77.

Decision rationale: This patient presents with chronic low back and right lower extremity pain. The treater is requesting Colace 100 mg #60 with 3 refills. The MTUS Guidelines page 77 on initiating therapy for opiate use states that prophylactic treatment of constipation should be initiated when opioids are prescribed. The records show that the patient has been prescribed Colace since 01/17/2014. The patient currently takes Norco for pain relief. In this case, MTUS allows the prophylactic treatment of constipation when opioids are prescribed. Therefore, this request is medically necessary.