MAXIMUS Federal Services

Case Number:	CM14-0013164		
Date Assigned:	02/24/2014	Date of Injury:	11/01/2003
Decision Date:	06/30/2014	UR Denial Date:	01/20/2014
Priority:	Standard	Application Received:	02/03/2014

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 & Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 72-year-old female who reported an injury on 11/01/2003. The mechanism of injury was not provided in the documentation. Per the clinical note dated 02/06/2014 the injured worker reported pain to the lumbar spine and to the right knee rating the lumbar pain as 8/10 and the right knee as 3/10. On physical examination, there was significant tenderness in the paralumbar musculature. There was paraspinous muscle spasm on the right, which was accentuated during range of motion, forward flexion was 15 degrees, extension 10 degrees, left and right tilt 10 degrees bilateral with increased pain and discomfort. The injured worker was reported to have a positive straight leg raise test, both in the seating and the supine positions. There was weakness of the foot dorsiflexor and toe extensor on the right, decreased sensation on the lateral aspect of the tibia and dorsum of the foot on the right. On physical examination of the right knee, there was no loosening; ligamentous stability was noted; flexion was 110 degrees, extension was full, sensation to the right lower extremity was diminished throughout. The diagnosis for the injured worker included status post right total knee arthroplasty, degenerative listhesis of the spine, and L4-5 disc herniation with right-sided radiculopathy. The Request for Authorization for medical treatment for the MRI of the lumbar spine was dated on 12/12/2013. The Request for Authorization for medical treatment for the Norco, the FluriFlex cream, and the TGIce cream was dated 01/09/2014. The provider's rationale for the medication--the Norco, the FluriFlex, and the TGIce--was for pain control. The rationale for the request for the MRI was evaluation of the lower spine. The injured worker previously underwent chiropractic treatment with gravity traction.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, LOW BACK REGARDING SPECIAL STUDIES AND DIAGNOSTIC AND TREATMENT CONSIDERATIONS CHAPTER 12, 303

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 303-310.

Decision rationale: Per CA MTUS/ACOEM guidelines no tests are recommended for nonspecific low back pain. The guidelines recommend an MRI when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative and MRI is the test of choice for patients with prior back surgery. Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion, such as false positive test results because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Imaging studies should be reserved for cases in which surgery is considered or red flag diagnoses are being evaluated. Because the overall false positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. The documentation provided noted the injured worker had a positive straight leg raise. There was a lack of documentation indicating whether diagnostic studies such as x-rays or electrodiagnostic studies were previously performed. There was a lack of objective findings that identified specific nerve compromise upon neurologic examination including decreased sensation, lower extremity weakness, and decreased reflexes. Therefore, the request for the MRI of the lumbar spine is not medically necessary.

NORCO 10/325 MG, #90 ONE PO Q4H PRN: 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, CRITERIA FOR USE OF OPIODS, 76-80

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Opioids Page(s): 74-80.

Decision rationale: Per the California MTUS Guidelines, opiates are seen as an effective method of controlling chronic pain. They are often used for intermittent and breakthrough pain; however, for continuous pain, extended release opioids are recommended. 4 domains have been proposed for ongoing monitoring of chronic pain: Side effects, pain relief, physical, and psychosocial functioning and the occurrence of any aberrant behavior. The monitoring of these

outcomes over time should affect therapeutic decisions and provide the framework of documentation of the clinical use of these controlled drugs. With regard to chronic back pain it appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. Failure to respond to a time limited course of opioids has led to the suggestion of re-assessment and consideration of alternative therapy. There was a lack of documentation regarding the use of this medication and the efficacy of that medication. There were no urine drug screens to determine if the injured worker was using the medication properly. There was a lack of documentation regarding clinical, physical, and psychosocial functioning improvements while on this medication and any side effects that the injured worker experienced. The documentation noted the injured worker received chiropractic treatments; however, there was a lack of documentation regarding the outcome of those treatments. In addition, the injured worker had been utilizing this medication long term and the guidelines note there is no evidence of long-term benefit or improvement in functioning when used for low back pain. Therefore, the request for Norco 10/325 #90 one PO Q4H PRN is not medically necessary.

FLURLFLEX (FLURBIPROFEN/CYCLOBENZAPRINE 15%/10%) CREAM 180 GM TO BE APPLIED TO THE AFFECTED AREA TWICE DAILY: 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, 111-113

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: Per the CA MTUS guidelines topical analgesics are recommended as an option as indicated below. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The efficacy of NSAIDs in clinical trials for topical treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. There is no evidence for use of any other muscle relaxant, such as cyclobenzaprine, for topical application. The addition of cyclobenzaprine to other agents is not recommended. Fluriflex is a compounded drug containing flurbiprofen and cyclobenzaprine. There was a lack of documentation regarding previous use of antidepressants or anticonvulsants and the efficacy of those medications. In addition, the guidelines state that cyclobenzaprine is not recommended as a topical agent and is not recommended to be an addition to other medications. There was a lack of documentation regarding the use of this medication and the efficacy of this medication. The request did not specify where the topical was to be used and topical NSAID's are not recommended for use on

the spine. Therefore, the request for fluriflex (flurbiprofen/cyclobenzaprine 15%/10%) cream 180 gm. to be applied to the affected area twice daily is not medically necessary.

TGICE (TRAMADOL/GABAPENTIN/MENTHOL/CAMPHOR 8/10/2/2%) CREAM 180 GM, TO BE APPLIED TO THE AFFECTED AREA TWICE DAILY: 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, 111-113

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: Per CA MTUS guidelines topical analgesics are recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety and primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no peer-reviewed literature to support the use of Gabapentin as a topical agent and it is therefore not recommended. In addition, Peer reviewed literature states that there is a deficiency of higher quality evidence on the role of topical opioids and that more robust primary studies are required to inform practice recommendations. There was a lack of documentation regarding previous use of antidepressants or anticonvulsants and the efficacy of those medications. There was a lack of documentation regarding the use of this medication and the efficacy of this medication. The request did not specify where the topical was to be used. Therefore, the request for TGICE (tramadol/gabapentin/menthol/camphor 8/10/2/2%) cream 180 gm., to be applied to the affected area twice daily: is not medically necessary.