

Case Number:	CM14-0015553		
Date Assigned:	02/28/2014	Date of Injury:	12/04/2012
Decision Date:	06/30/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/06/2014

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 Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Texas. 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:

The injured worker is a 42 year old female whose date of injury is 12/04/2012. She was scooping ice when her right foot slipped and her body jerked in an awkward motion. EMG/NCV dated 07/25/13 revealed findings suggestive of bilateral S1 radiculopathy. Lumbar MRI dated 11/06/13 revealed no evidence of posterior disc protrusions, facet arthropathy bilaterally at L4-5 and L5-S1 with mild bilateral neural foraminal stenosis, mild disc desiccation at L4-5 and S1, and mild hyperlordosis of the distal lumbar spine. Progress report dated 01/24/14 indicates that she complains of low back pain and right lower extremity radiculopathy. On physical examination lumbar range of motion is flexion 30, extension 10, bilateral rotation 20 and bilateral tilt 10 degrees. Diagnosis is L4-5 and L5-S1 discopathy with right sided radiculopathy. She is noted to be in physical therapy and has 3 sessions remaining. The injured worker continues to work full duty.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY X 8 LUMBAR 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 GUIDELINES,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58-60.

Decision rationale: Based on the clinical information provided, the request for physical therapy x 8 lumbar spine is not recommended as medically necessary. The submitted records indicate that the injured worker has completed at least 8 physical therapy visits to date. The injured worker's objective functional response to this treatment is not documented to establish efficacy of treatment and support additional sessions. The California MTUS guidelines would support 1-2 visits every 4-6 months for recurrence/flare-up and note that elective/maintenance care is not medically necessary. There are no specific, time-limited treatment goals provided. The request for Physical Therapy x 8 Lumbar Spine is not medically necessary.

EIGHT AQUA THERAPY SESSIONS 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: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, AQUATIC THERAPY,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AQUATIC THERAPY Page(s): 22.

Decision rationale: Based on the clinical information provided, the request for eight aqua therapy sessions for the lumbar spine is not recommended as medically necessary. The California MTUS guidelines support aquatic therapy when reduced weightbearing is desirable. It is unclear why reduced weightbearing would be desirable for this injured worker. The injured worker has completed a course of land-based physical therapy and is noted to be working full time. There are no specific, time-limited treatment goals provided.

FLURIFLEX (FLURBIPROFEN/CYCLOBENZAPRINE 15/10%) CREAM 180GM:
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 ANALGESICS Page(s): 112-113. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, COMPOUNDED MEDICATIONS

Decision rationale: The request for Fluriflex (Flurbiprofen/Cyclobenzaprine 15/10% Cream 180 Gm is not medically necessary. The California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: flurbiprofen 15 % and cyclobenzaprine 10% which have not been approved

by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended, and is therefore not medically necessary.

TRAMADOL/GABAPENTIN/MENTHOL/CAMPHOR 8/10/2.2% CREAM 180GM:

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 ANALGESICS Page(s): 112-113. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, COMPOUNDED MEDICATIONS

Decision rationale: The request for Tramadol/Gabapentin/Menthol/Camphor 8/10/2.2% Cream 180 Gm is not medically necessary. The California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: Tramadol and Gabapentin which have not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended, and therefore is not medically necessary.

RETRO URINALYSIS: 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, ,

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

Decision rationale: The request for urinalysis is not supported as medically necessary. The submitted clinical records provide no data to support the need for routine urinalysis.