

<b>Case Number:</b>	CM14-0018258		
<b>Date Assigned:</b>	04/21/2014	<b>Date of Injury:</b>	04/13/2012
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	02/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 Occupational Medicine 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 an employee of [REDACTED] and has submitted a claim for cervical strain with headaches, and lumbar strain associated with an industrial injury date of 04/13/2012. The treatment to date has included L4-L5 epidural steroid injection on 10/23/2013, chiropractic care, acupuncture, and medications including acetaminophen, Polar Freeze topical gel, Etodolac, and Flexeril. The medical records from 2013 were reviewed showing that patient complained of low back pain radiating to bilateral lower extremities aggravated upon lifting, prolonged sitting and standing more than 15 minutes. It was described as dull, intermittent, and graded 5/10 in severity. Patient likewise complained of intermittent neck pain varying in intensity that radiates to bilateral upper extremities. Intake of medications alleviated the pain. Physical examination showed paracervical, paralumbar and lumbosacral tenderness and muscle spasm. Lumbar spine range of motion was normal. Motor strength for upper and lower extremities was graded 5/5. Deep tendon reflexes were equal and symmetric. Patrick sign, FABER, and thigh thrust provocative tests were positive at left. Sensation was diminished at left L3-L4 dermatomes. Patient had difficulty performing both heel-walk and toe-walk. MRI of the lumbar spine, dated 06/01/2013, revealed L4-L5 mild canal stenosis with 8mm central disc protrusion contact bilateral descending L5 nerve roots; and L5-S1 central disc protrusion with annular tear effaces anterior thecal sac. A utilization review from 02/04/2014 denied the requests for physiotherapy L/S, Qty: 8 due to lack of documentation of symptomatic or functional improvement from previous therapy sessions; tramadol because this is not recommended as a first-line oral analgesic drug; Relafen due to unspecified dosage and quantity; cream due to unproven efficacy of topical analgesics; and Lidoderm patch because of unspecified quantity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSIOTHERAPY L/S QTY: 8.00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** As stated on pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. In this case, the patient already had physical therapy starting on February 2013; however, the exact number of sessions completed is unknown due to lack of documentation. Furthermore, medical records submitted and reviewed do not reflect functional improvements derived from physical therapy. Likewise, the patient should be well-versed with a self-directed exercise program by now. Therefore, the request for physiotherapy L/S, Qty: 8 is not medically necessary.

**PRESCRIPTION FOR TRAMADOL (UNSPECIFIED DOSAGE AND QUANTITY): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Guidelines, Tramadol (Ultram, Ultram Er, Generic Available In Immediate Release Tablet) Page(s): 93-94, 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75, 113.

**Decision rationale:** As stated on page 75 of Chronic Pain Medical Treatment Guidelines, central acting analgesics are an emerging fourth class of opiate that may be used to treat chronic pain. Tramadol is reported to be effective in managing neuropathic pain. In this case, the patient has been using Tramadol as early as March 2013. Per the guidelines cited on page 113, opioids should be continued if the patient has returned to work and if the patient has improved functioning and pain. The medical records showed no evidence of improved function (i.e., in terms of specific activities of daily living) and pain relief (i.e., documented via pain scale) through the prior usage of Tramadol. Furthermore, the present request does not specify the dosage and amount of medication to dispense. Therefore, the request for prescription for Tramadol (unspecified dosage and quantity) is not medically necessary.

**PRESCRIPTION FOR RELAFEN (UNSPECIFIED DOSAGE AND QUANTITY): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 67-73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68.

**Decision rationale:** As stated on pages 67-68 of the California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are useful in treating breakthrough and mixed pain conditions such as neuropathic pain, osteoarthritis, and back pain. NSAIDs are recommended as an option for short-term symptomatic relief for chronic low back pain. Review of literature suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. In this case, it is unknown if the patient has started using Relafen due to lack of documentation. He has been prescribed with Tramadol, acetaminophen, cyclobenzaprine, and Etodolac in the past; however, he still has persistent low back pain. The medical necessity has been established. However, there is no indication that Relafen is being prescribed as a short-term symptomatic relief only per the guideline recommendations stated above. Furthermore, the present request does not specify the dosage and amount of medication to dispense. Therefore, the request for prescription for Relafen (unspecified dosage and quantity) is not medically necessary.

**PRESCRIPTION FOR CREAM (UNSPECIFIED):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 111-113.

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

**Decision rationale:** As stated on page 111 of CA MTUS Chronic Pain Medical Treatment guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the present request does not specify the name of the prescribed cream. Furthermore, there is no indicated dosage and quantity to dispense. Therefore, the prescription for cream (unspecified) is not medically necessary.

**PRESCRIPTION FOR LIDODERM PATCH (UNSPECIFIED DOSAGE AND QUANTITY):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 56-57.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

**Decision rationale:** As stated on pages 56-57 of Chronic Pain Medical Treatment Guidelines, topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-

herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain. In this case, the patient has been using Lidoderm patch since October 2013. However, he has been complaining of low back pain radiating to bilateral lower extremities, and neck pain with intermittent radiation to bilateral upper extremities. This is not considered as a localized type of peripheral pain which should be the indication for topical lidocaine as stated above. Likewise, medical records do not show that the patient was previously prescribed with tricyclic or SNRI antidepressants to manage his condition per the guideline recommendations. In addition, the present request does not specify the dosage and amount of medication to dispense. Therefore, the request for prescription for Lidoderm patch (unspecified dosage and quantity) is not medically necessary.