MAXIMUS Federal Services

Case Number:	CM14-0114388		
Date Assigned:	08/27/2014	Date of Injury:	04/07/2014
Decision Date:	09/25/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	07/22/2014

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:

Patient is a 31-year-old female who has submitted a claim for lumbar sprain and strain, neck sprain and strain, thoracic sprain and strain, and headache associated with an industrial injury date of 4/7/2014. Medical records from 2014 were reviewed. The patient complained of neck pain, rated 4/10 in severity, associated with tightness and stiffness. Patient also complained of constant mid and low back pain, rated 5 to 8/10 in severity, radiating to the left lower extremity. She likewise experienced bilateral shoulder pain with radiation to trapezius. Alleviating factors included rest and medications. Physical examination showed spasms and tenderness at paralumbar muscles. Sciatic notch tenderness was noted. Patient's height is 66 inches tall, weight of 240 pounds, with a body mass index of 40.1 kg/m2. Range of motion of the thoracic spine, lumbar spine, and both shoulders was restricted. Straight leg raise test was positive at the left. Mild weakness was noted at C6 and L5 myotomes, bilaterally. Sensory was intact. Reflexes were equal bilaterally. Treatment to date has included physical therapy x 6 sessions, and medications such as Vicodin and naproxen (since June 2014). Utilization review from 7/9/2014 denied the request for Aquatic therapy x 12 visits, cervical/thoracic/lumbar spine and upper and lower extremities because there was no documented functional improvement from previous sessions; denied Flurbiprofen 20% cream 120 gr, Ketoprofen 20%/Ketamine 10% cream 120 gr, and Gabapentin 10%/Cyclobenzaprine 10%/Capsaicin 0.0375% cream 120 gr because of lack of published studies concerning its efficacy and safety; and denied Final confirmation of urine drug test results because there was no concern for aberrant drug behavior.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic therapy x 12 visits, cervical/thoracic/lumbar spine and upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22-23.

Decision rationale: As stated on pages 22-23 of the California MTUS Chronic Pain Medical Treatment Guidelines, aquatic therapy is recommended as an alternative to land-based physical therapy where reduced weight bearing is desirable such as extreme obesity or fractures of the lower extremity. In this case, patient is extremely obese with a body mass index of 40.1 kg/m2; hence, aquatic therapy may be recommended. However, utilization review stated that patient completed 6 sessions of physical therapy and functional outcomes from these sessions were not documented. The medical necessity cannot be established due to insufficient information. Therefore, the request for Aquatic therapy x 12 visits, cervical/thoracic/lumbar spine and upper and lower extremities is not medically necessary.

Flurbiprofen 20% cream 120 gr: Upheld

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

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

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. In addition, there is little to no research as for the use of flurbiprofen in compounded products. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains Flurbiprofen, which is not recommended for topical use. There is no discussion concerning need for variance from the guidelines. Therefore, the request for Flurbiprofen 20% cream 120 gr is not medically necessary.

Ketoprofen 20%/Ketamine 10% cream 120 gr: Upheld

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

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

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized

controlled trials to determine safety or efficacy. Ketoprofen is not recommended for topical use as there is a high incidence of photo contact dermatitis. Ketamine is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains ketoprofen and ketamine, which are not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. Therefore, the request for Ketoprofen 20%/Ketamine 10% cream 120 gr is not medically necessary.

Gabapentin 10%/Cyclobenzaprine 10%/Capsaicin 0.0375% cream 120 gr: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Topical Analgesics Page(s): 28-29, 111-113.

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. CA MTUS does not support the use of opioid medications and gabapentin in a topical formulation. Cyclobenzaprine is not recommended for use as a topical analgesic. CA MTUS Chronic Pain Medical Treatment Guidelines identifies on page 28 that topical Capsaicin is only recommended as an option if there was failure to respond or intolerance to other treatments. The guideline states there is no current indication that an increase over a 0.025% formulation of capsaicin would provide any further efficacy. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains gabapentin, cyclobenzaprine, and capsaicin 0.0375%, which are not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. Therefore, the request for Gabapentin 10%/Cyclobenzaprine 10%/Capsaicin 0.0375% cream 120 gr is not medically necessary.

Final confirmation of urine drug test results: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back-Lumbar & Thoracic (Acute & Chronic).

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

Decision rationale: Page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that urine drug screens are recommended as an option to assess order use or presence of illegal drugs and as ongoing management for continued opioid use. Screening is recommended randomly at least twice and up to 4 times a year. In this case, current treatment regimen includes Vicodin. No urine drug screens have been accomplished in the past. Screening is a reasonable

diagnostic option at this time to monitor drug compliance. Therefore, the request for Final confirmation of urine drug test results is medically necessary.