

Case Number:	CM14-0022325		
Date Assigned:	05/09/2014	Date of Injury:	12/05/1997
Decision Date:	08/11/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	02/21/2014

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 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 injured worker is a 70-year-old female who reported an injury on 07/16/1996. The mechanism of injury was not provided within the medical records. The clinical note dated 12/12/2013 indicated diagnoses of mid-thoracic strain and lumbar disc herniation. The injured worker reported persistent thoracolumbar pain on physical examination of the thoracolumbar spine. The injured worker had spasms and tenderness in the paraspinal muscles with pain on range of motion. The injured worker's prior treatments included diagnostic imaging, physical therapy, and medication management. The provider submitted a request for medications and physical therapy. A Request for Authorization was submitted for ibuprofen, Robaxin, FluoroFlex cream, TGICE cream, and 8 physical therapy visits for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

IBUPROFEN 800MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The CA MTUS guidelines recognize anti-inflammatories as the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. The documentation submitted did not indicate if the injured worker had tried acetaminophen. In addition, there was a lack of documentation of efficacy and functional improvement with the use of this medication. Moreover, the request did not indicate a frequency or quantity for this medication. Furthermore, the provider did not indicate a rationale for the request. Therefore, the request for ibuprofen is not medically necessary.

ROBAXIN 750MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 65.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines state Robaxin is an antispasmodic used to decrease muscle spasm in conditions such as LBP although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. The documentation submitted did not indicate if the injured worker had tried and failed acetaminophen. In addition, there was a lack of documentation of efficacy and functional improvement with the use of this medication. Moreover, the request did not indicate a frequency or quantity for this medication. Furthermore, the provider did not indicate a rationale for the request. Therefore, the request is not medically necessary.

FLURIFLEX CREAM 180GM: Upheld

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

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

Decision rationale: Fluriflex contains (flurbiprofen/cyclobenzaprine). The California Chronic Pain Medical Treatment Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficiency or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Flurbiprofen is an NSAID indicated for osteoarthritis and tendonitis. The documentation

submitted did not indicate the injured worker had findings that would support she was at risk for osteoarthritis or tendonitis. In addition, topical analgesics are largely experimental and are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation submitted did not indicate the injured worker had tried and failed antidepressants or anticonvulsants. Moreover, FluriFlex contains cyclobenzaprine, a muscle relaxant. The guidelines indicate there is no evidence for use of any muscle relaxant as a topical product. Per the guidelines, any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Furthermore, the request did not indicate a frequency or quantity. Moreover, there was a lack of documentation of efficacy and functional improvement with the use of this medication. Therefore, the request of FluoroFlex cream is not medically necessary.

TGICE CREAM 180GM: Upheld

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

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

Decision rationale: TG Ice contains (Tramadol/Gabapentin/Menthol/Camphor) cream. The California Chronic Pain Medical Treatment Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficiency or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Topical analgesics are largely experimental and primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation submitted did not indicate the injured worker had tried and failed antidepressants or anticonvulsants. In addition, TGICE contains gabapentin. Per the guidelines, any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. In addition, there is a lack of documentation of efficacy and functional improvement with the use of this medication. Moreover, the request did not indicate a frequency or quantity for this medication. Therefore, the request for TGICE is not medically necessary.

8 PHYSICAL THERAPY VISITS FOR THE LUMBAR SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: The California MTUS state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The guidelines note injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. It was indicated that the injured worker had prior sessions of physical therapy. However, there is a lack of documentation indication the injured worker's prior course of physical therapy, as well as the number of sessions and efficacy of the prior therapy to warrant additional sessions of therapy. In addition, there was a lack of documentation, including an adequate and complete physical exam demonstrating the injured worker has decreased functional ability, decreased range of motion, and decreased strength or flexibility. Moreover, the completed physical therapy should have been adequate to improve functionality and transition the injured worker to a home exercise program, where the injured worker may continue exercises such as strengthening, stretching, and range of motion. Additionally, the request did not indicate a timeframe for the physical therapy. Therefore, the request for 8 physical therapy visits for the lumbar spine is not medically necessary.