MAXIMUS Federal Services

Case Number:	CM14-0032153		
Date Assigned:	06/20/2014	Date of Injury:	08/01/2002
Decision Date:	08/15/2014	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	03/13/2014

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 Physical Medicine & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 64-year-old female who reported an injury on 08/01/2002. The mechanism of injury was not provided within the medical records. The clinical note dated 02/28/2014 indicated diagnoses of spinal sprain/strain syndrome, right knee internal derangement, right knee contusion, morbid obesity status post gastric bypass surgery, lumbar discopathy, and bilateral knee patellofemoral chondromalacia. The injured worker reported that her low back pain persisted with radiation to the bilateral lower extremities. She reported aching and burning pain rated 8/10. The injured worker reported right knee pain rated 8/10. The injured worker reported ongoing burning, stabbing pain to the left shoulder with pins and needles sensation in her left arm. The injured worker reported trouble sleeping sometimes, reported weakness and weight gain. On physical examination, the injured worker had an antalgic gait. The injured worker's toe and heel walk were compromised bilaterally. On physical examination of the lumbar spine, there was significant tenderness in the paralumbar musculature. Forward flexion was 15 degrees; extension was 10 degrees, tilts to the right and left was 10 degrees with increased pain and discomfort. The injured worker had weakness of foot dorsiflexor and toe extensor bilaterally. There was decreased sensation on the lateral aspect of the tibia and dorsum of the foot bilaterally. The injured worker had sciatic stretch signs and positive straight leg raise testing at 40 -50 degrees bilaterally, in both the supine and seated positions. The injured worker's contralateral straight leg raise test produced back pain on straight leg raise testing of 70- 75 degrees, both in seated and supine positions. The examination of the right knee patellar tracking was abnormal. The patellar grind maneuver was positive. There was tenderness to the hamstring. There was also tenderness over the medial and lateral aspects. There was mild effusion present. The injured worker had a positive McMurray's test. The injured worker's varus/valgus stress test was mildly positive. The injured worker reported her pain medications were helping her. The

injured worker's prior treatments included diagnostic imaging, surgeries, physical therapy, and medication management. The injured worker's medication regimen included Norco, Fluriflex, and THIce. The provider submitted a request for physical therapy, Norco, Fluriflex, THIce, and a retrospective urinalysis. A Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy; eight sessions two times four for the lumbar spine: Upheld

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

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

Decision rationale: The request for physical therapy eight sessions two times per week for four weeks in treatment of the lumbar spine is not medically necessary. 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. There is a lack of documentation indicating the injured worker's prior course of physical therapy as well as the efficacy of the prior therapy, including the number of sessions. In addition, 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 with exercises such as strengthening, stretching, and range of motion. Therefore, the request for physical therapy eight sessions two times per week for four weeks in treatment of the lumbar spine is not medically necessary.

Norco 10/325 #60, one po q6-8h with two refills: Upheld

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

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

Decision rationale: The request for Norco 10/325 #60, one by mouth every 6-8 hours, with two refills is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of quantified pain relief and functional improvement with the use of this medication. In addition, there was a lack of significant evidence of the injured

worker's pain level, evaluation of risk for aberrant drug use behaviors, and side effects. Therefore, the request is not medically necessary.

Fluriflex (Flurbiprofen/Cyclobenzaprine 15/10%) cream 180 gm to be applied to the affected area twice daily: Upheld

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

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

Decision rationale: The request for Fluriflex (Flurbiprofen/Cyclobenzaprine 15/10%) cream 180 gm to be applied to the affected area twice daily is not medically necessary. 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. Fluriflex contains flurbiprofen, which is an NSAID. It is recommended for short-term use. The documentation submitted did not indicate how long the injured worker had been utilizing this medication. In addition, the documentation submitted did not indicate the injured worker had findings that would support she was at risk for osteoarthritis or tendonitis. Moreover, Fluriflex contains cyclobenzaprine, which is a muscle relaxant. The guidelines indicate there is no evidence for use of any other muscle relaxant as a topical product. Cyclobenzaprine is not recommended. The guidelines indicate any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Additionally, the request did not indicate a frequency or quantity for this medication. Therefore, per the California MTUS Guidelines, the request for Fluriflex is not medically necessary.

THIce (Tramadol/Gabapentin/Menthol/Camphor 8/10/2/2%) cream 180gm to be applied to affected area twice daily: Upheld

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

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

Decision rationale: The request for THIce (Tramadol/Gabapentin/Menthol/Camphor 8/10/2/2%) cream 180gm to be applied to affected area twice daily is not medically necessary. 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. The documentation submitted did not indicate the injured worked had tried and failed antidepressants and anticonvulsants. In addition, THIce contains gabapentin, which is a muscle relaxant. The guidelines indicate there is no evidence for use of any other muscle relaxant as a topical product. Gabapentin is not recommended. The guidelines indicate any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Moreover, there was lack of documentation of efficacy and functional improvement with the use of this medication. Furthermore, the request did not indicate a frequency or quantity for this medication. Therefore, per the California MTUS Guidelines, the request for THIce is not medically necessary.

Retrospective urinalysis DOS 01/23/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Test Page(s): 43.

Decision rationale: The request for retrospective urinalysis (DOS 01/23/14) is not medically necessary. The California MTUS guidelines recommend a urine drug test as an option to assess for the use or the presence of illegal drugs. It may also be used in conjunction with a therapeutic trial of Opioids, for on-going management, and as a screening for risk of misuse and addiction. The documentation provided did not indicate the injured worker displayed any aberrant behaviors, drug-seeking behaviors, or whether the injured worker was suspected of illegal drug use. In addition, the provider did not indication a rationale for the request. Therefore, the request for retrospective urinalysis is not medically necessary.