

Case Number:	CM14-0051101		
Date Assigned:	07/07/2014	Date of Injury:	11/15/2013
Decision Date:	08/29/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/18/2014

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 Anesthesiology, has a subspecialty in Pain Management, and is licensed to practice in Florida. 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 45-year-old who reported an injury on November 15, 2013. The mechanism of injury was a slip and fall on a wet floor. The injured worker underwent therapy and had an x-ray. The documentation of February 7, 2014 revealed the injured worker had complaint of the coccyx, cervical spine, left knee, and lumbar spine as well as thoracic spine. The physical examination revealed pain on range of motion. The axial compression test, distraction test, and shoulder depression test were positive bilaterally. The biceps reflexes were noted to be decreased. The injured worker had +3 spasm and tenderness to the bilateral lumbar paraspinal muscles from L1-S2, the base of the coccyx and multifidus. The Kemp's test and Yeoman's test were positive bilaterally. The straight leg raise was positive on the right. The right Achilles reflex was decreased. The S1 dermatome was decreased on the right to light touch. The diagnosis included lumbar disc displacement without myelopathy, cervical disc herniation with myelopathy, lumbar thoracic disc displacement without myelopathy, a tear of the medial meniscus of the left knee, and bursitis of the left knee. The physician opined the injured worker's care should be dictated by the Chronic Pain Medical Treatment Guidelines for patients with more complex and refractory problems, a comprehensive multidisciplinary approach to pain management that is individualized, functionally oriented (not pain oriented), and goal specific, has been found to be the most effective treatment approach. The physician documented they would use range of motion, the Visual Analog Scale, QFCE evaluations, and work restrictions to monitor functional improvement. The request was made for a program of physical medicine for twelve visits with continuation dependent upon functional improvement, multi-interferential stimulator 1 month rental, and an MRI 3D of the left knee. There was no PR-2 or DWC Form RFA submitted with the requested procedures.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, FCE.

Decision rationale: The Cornerstones of Disability Prevention and Management Chapter of the ACOEM Practice Guidelines indicate there is a functional assessment tool available and that is a Functional Capacity Evaluation, however, it does not address the criteria. As such, secondary guidelines were sought. Official Disability Guidelines indicates that a Functional Capacity Evaluation is appropriate and is recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. The clinical documentation submitted for review failed to support the necessity for a Functional Capacity Evaluation. There was no DWC Form RFA or PR-2 submitted for the requested procedure. Given the above, the request for Functional Capacity Evaluation is not medically necessary or appropriate.

Work Hardening Screening Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work Hardening Page(s): 125.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicate that the criteria for admission into a work hardening program include the injured worker must have a work related musculoskeletal condition with functional limitations precluding their ability to safely achieve current job demands which are medium or higher demand level. A Functional Capacity Evaluation may be required showing consistent results with maximal effort demonstrating capacities below an employer verified physical demands analysis. After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, there should be documentation the injured worker is not likely to benefit from continued physical or occupational therapy or general conditioning. There should be documentation the injured worker is not a candidate where surgery or other treatments would clearly be warranted to improve function. The clinical documentation submitted for review failed to provide documentation indicating the injured worker was not a candidate for surgery or other treatments, and that the injured worker had a trial of physical or occupational therapy with improvement followed by plateau. There was no DWC Form RFA or PR-2 submitted for review for the requested

intervention. Given the above, the request for work hardening screening evaluation is not medically necessary or appropriate.

Lidocaine 6%, Gabapentin 1%, Tramadol 1% 180 mg with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Gabapentin, Topical Analgesics, Topical Salicylates, Lidocaine Page(s): 82, 113, 111, 105, 112. Decision based on Non-MTUS Citation FDA.gov.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicated that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical Salicylates are recommended. A thorough search of FDA.gov, did not indicate there was a formulation of topical Tramadol that had been FDA approved. The approved form of Tramadol is for oral consumption, which is not recommended as a first line therapy. Gabapentin: Not recommended. There is no peer-reviewed literature to support use. The guidelines indicate that topical lidocaine (Lidoderm) 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). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation of a DWC Form RFA or PR-2 to support the use of the medication. There was a lack of documentation indicating a necessity for 2 topical creams with lidocaine. There was a lack of documentation indicating a necessity for 2 refills without re-evaluation. There was a lack of documentation indicating the injured worker had neuropathic pain and that antidepressants and anticonvulsants had failed. There was a lack of documentation indicating exceptional factors to warrant nonadherence to guideline and FDA recommendations. The request as submitted failed to indicate the frequency for usage. There was no DWC Form RFA or PR-2 submitted for the requested medication. The duration of use could not be established. Given the above, the request for Lidocaine 6%, Gabapentin 1%, Tramadol 1% 180 mg with two refills is not medically necessary or appropriate.

Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5% 180 mg with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Topical Analgesics, Lidocaine, Baclofen, Flurbiprofen Page(s): 41, 111, 112, 113, 72.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no peer-reviewed literature to support the use of topical baclofen. The guidelines do not recommend the topical use of Cyclobenzaprine as a topical muscle relaxants as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine to other agents is not recommended. The guidelines indicate that topical lidocaine (Lidoderm) 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). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Regarding Topical Flurbiprofen. FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine - National Institute of Health (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration. The request as submitted failed to indicate the frequency for the requested medication. There was lack of documentation indicating a necessity for 2 topical products including lidocaine as an ingredient. There was a lack of documentation indicating a necessity for 2 refills without re-evaluation. The duration of use could not be established through supplied documentation. There was a lack of documentation indicating the injured worker had neuropathic pain and a trial and failure of antidepressants and anticonvulsants. There was no DWC Form RFA or PR-2 submitted for the requested medication. Given the above, the request for Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5% 180 mg with two refills is not medically necessary.