

Case Number:	CM14-0052589		
Date Assigned:	07/07/2014	Date of Injury:	05/16/2011
Decision Date:	08/08/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/21/2014

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 Orthopaedic Surgery 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:

This 55-year-old male sustained an industrial injury on 3/16/11, relative to cumulative work duties. Records indicated the patient was under treatment for bilateral shoulder and low back pain with left lower extremity radicular symptoms. The patient underwent bilateral L4/5 and L5/S1 epidural steroid injections in September 2013 with 80% relief. The 3/10/14 treating physician report cited grade 2/10 left shoulder, grade 5/10 right shoulder, and grade 7/10 low back pain radiating to the left lower extremity with numbness and tingling. Shoulder and low back pain was alleviated by medications and rest. Conservative treatment had included lumbar epidural steroid injections, acupuncture, 24 sessions of physical therapy without improvement, and a home exercise program. Current medications included Flexeril, omeprazole, Relafen, and topical creams. Lumbar exam documented bilateral paralumbar muscle tenderness with positive orthopedic tests. Right shoulder exam documented flexion 90 degrees, abduction 95 degrees, and 4-/5 weakness. The patient was pending a general surgery consult for hernia, and orthopedic spine, psychiatric, and urology consults. A request for right shoulder manipulation under anesthesia was pending. The treatment plan requested authorization for medications including Flexeril 7.5 mg twice a day #90 and topical creams TGHot and FlurFlex. Pain management consult was recommended for consideration of a second lumbar epidural steroid injection. Medication allergy was documented to Tramadol. The 3/24/14 utilization review modified the request for Flexeril 7.5 mg #90 to #20 as there was no documentation of spasms or acute exacerbation of low back pain and weaning was indicated. The requests for topical analgesic creams (TGHot and FlurFlex) were denied based on the absence of guideline support. The request for physical therapy was denied, as there was no documentation of prior functional improvement with physical therapy treatment or medical necessity for care prior to the proposed manipulation under anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, Antispasticity Drugs, Antispasmodic Drugs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Muscle relaxants, Antispasticity Drugs, Antispasmodic Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Muscle relaxants (for pain) Page(s): 41-42, 63-65.

Decision rationale: The California MTUS guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic lower back pain. Flexeril is not recommended to be used for longer than 2 to 3 weeks. Guideline criteria have not been met for use of this medication. Records indicate that this patient has been prescribed Flexeril since at least 4/5/12. There is no current documentation suggestive of an acute exacerbation of low back pain or muscle spasms. The 3/24/14 utilization review partially certified #20 Flexeril 7.5 mg to allow for medication weaning. The prescribed amount would equal #60 tablets per month. There is no compelling reason to support the medical necessity of this medication beyond the partial certification. Therefore, this request for Flexeril 7.5 mg #90 is not medically necessary.

Topical Cream TGHOT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, NSAIDs.

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

Decision rationale: TGHOT is a topical compound containing tramadol, gabapentin and capsaicin. The California MTUS state that any compounded product that contains at least one drug that is not recommended is not recommended. Guidelines indicate that topical analgesics in general are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Capsaicin is supported as an option in patients who have not responded or are intolerant to other treatments. Topical gabapentin is not recommended by the guidelines. There are no high-quality literary studies or guidelines which support the safety or efficacy of tramadol utilized topically. Additionally, this patient is noted to be allergic to tramadol. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request for TGHOT topical cream is not medically necessary.

Topical Cream FlurFlex: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, NSAIDs.

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

Decision rationale: FlurFlex is a topical compound containing Flurbiprofen and cyclobenzaprine. The California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical agents are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines state there is no evidence for use of a muscle relaxant, such as cyclobenzaprine, as a topical product. Guidelines do not recommend topical non-steroid anti-inflammatory drugs (NSAIDs), like Flurbiprofen, for neuropathic pain and state there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine or shoulder. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request for FlurFlex topical cream is not medically necessary.

Physical Therapy 2 x 3 for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC).

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

Decision rationale: The California MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. Treatment efficacy is to be reported by functional improvement. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. Guideline criteria have not been met. This patient has received 24 visits of physical therapy without improvement according to the most recent treating physician report. Records indicate that a request for shoulder manipulation under anesthesia is pending to address the significant loss of shoulder motion. Physical therapy prior to manipulation under anesthesia, in the absence of prior functional improvement, is not supported by guidelines. Additional physical therapy following the procedure would be appropriate. Therefore, this request for physical therapy 2 times per week for 3 weeks for the right shoulder is not medically necessary.

Pain Management Consultation: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Evaluation and Management.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition (2004), Chapter 7: Independent Medical Examinations and Consultations, page 127.

Decision rationale: The California MTUS guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for treatment of a patient. Guideline criteria have been met. This request for pain management consultation was recommended for consideration of repeat lumbar epidural steroid injections. Benefit documented to prior lumbar epidural steroid injections is consistent with guidelines to allow consideration of repeat injections. Therefore, this request for pain management consultation is medically necessary.