MAXIMUS Federal Services

Case Number:	CM14-0099478		
Date Assigned:	07/28/2014	Date of Injury:	01/15/2013
Decision Date:	08/29/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	06/27/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 49-year-old male who reported an injury on 01/15/2013. The mechanism of injury is not provided. The injured worker has a diagnosis of L4-5 and L5-S1 disc herniation with right sided radiculopathy and mild right lower extremity foot drop and left shoulder impingement. Past treatments have included medications, back support and home exercise program. His diagnostic studies include EMG/NCS on 08/26/ 2013, x-rays and MRI of the lumbar spine on 09/05/2013, urine drug screen on 09/25/2013, 10/23/2013, 11/6/2013, 12/04/2013, and 05/21/2914. On 05/21/2014, the injured worker was seen for low back pain that radiated into the lower extremities. There was numbness and tingling. On examination of the lumbar spine, there was tenderness in the paraspinous musculature. Midline tenderness was noted in the lumbar region. Surgical history was not provided. Medications were noted to include Norco 10/325, Tramadol ER 150 mg, Cyclobenzaprine 7.5 mg, Fluriflex topical cream and TGHot topical cream and Motrin. The injured worker had improvement with medications. The plan of treatment is for Hydrocodone/APAP 10/325 1 by mouth every 6 to 8 hours as needed for pain, Tramadol ER 150 mg 1 to 2 every day for pain, Cyclobenzaprine 7.5 mg one at hour of sleep or 1 every 12 hours as needed for muscle spasm, Motrin 800 mg for anti-inflammatory, Fluriflex to affected area twice a day and TGHot cream to affected area twice a day for pain relief. The rationale was to eliminate pain. The Requests for Authorization are signed for 05/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg 1 every 6-9 hours: 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 California MTUS, Norco, page 75, Ongoing Management, page 78 Page(s): 75; 78.

Decision rationale: The request for Norco 10/325mg 1 every 6-9 hours is not medically necessary. The injured worker had a history of back and shoulder pain. This was prescribed to relieve or reduce the intensity of the injured worker's moderate to severe somatic, neuropathic and visceral pain. California MTUS guidelines recommend short acting opioids such as Norco for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. There is lack of documentation s to the effectiveness, improvement of daily living, side effects and aberrant behavior for said medication. As such, the request is not medically necessary.

Tramadol ER 150mg, 1-2 daily, #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, page 82, 93, 94, 113, Ongoing management page 78 Page(s): 82, 93, 94, 113; ,page 78.

Decision rationale: The request for Tramadol ER 150mg, 1-2 daily, #60 with 2 refills is not medically necessary. The injured worker has a history of back and shoulder pain. This is to be utilized for control. California MTUS states Central analgesics drugs such as Tramadol (Ultram) are reported to be effective in managing neuropathic pain and it is not recommended as a first-line oral analgesic. California MTUS recommend that there should be documentation of the 4 A's for Ongoing Monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. There is lack of documentation of ongoing monitoring of said medications. As such, the request is not medically necessary.

Cyclobenzaprine 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine and Muscle Relaxants Page(s): 41, 64.

Decision rationale: The request for Cyclobenzaprine 7.5mg #60 is not medically necessary. The injured worker has a history of back pain. The cyclobenzaprine is to be used for spasm.

California MTUS states that Cyclobenzaprine (Flexeril) is recommended for a short course of therapy. Flexeril is more effective than placebo in the management of back pain; however, the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. This medication is not recommended to be used for longer than 2-3 weeks. There is lack of documentation to support the long term use of said medication. Also there is no frequency given within the request. As such, the request is not medically necessary.

Fluriflex topical cream: Upheld

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

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

Decision rationale: The request for Fluriflex topical cream is not medically necessary. The injured worker has a history of back and shoulder pain. According to the California MTUS Guidelines, topical analgesics are largely experimental in the use with limited evidence demonstrating efficacy and safety, and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state that compounded products that contain at least one drug that is not recommended are not recommended. Topical NSAIDs may be recommended for the treatment of osteoarthritis pain for joints that lend themselves to topical treatment, but they have not been evaluated for treatment of the spine, hip, or shoulder. The guidelines also state there is no evidence for use of muscle relaxants as topical products. As such, the request is not medically necessary.

TG Hot topical cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, pages 111-113; Topical Salicylates, page 105 Page(s): 111-113.

Decision rationale: The request for TG Hot topical cream is not medically necessary. The injured worker has a history of back pain. TGHot contains Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2% and Capsaicin 0.05%. According to the California MTUS Guidelines, topical analgesics are largely experimental in the use with limited evidence demonstrating efficacy and safety, and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state that compounded products that contain at least one drug that is not recommended are not recommended. The guidelines further state that topical salicylates are recommended as they have been shown to be better than placebo in chronic pain. However, Gabapentin is not recommended by the guidelines as there is no peer-reviewed literature to support topical use and capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. The

documentation submitted for review did not include clear documentation of non-response or intolerance to first line medications to warrant use of topical capsaicin. In addition, the guidelines do not recommend Gabapentin. Therefore, as the requested topical compound contains drugs that are not recommended, the compounded product is also not recommended. As such, the request is not medically necessary.