

<b>Case Number:</b>	CM14-0200409		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	09/14/2011
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	11/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabn

### 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 patient is a 48 year old male with date of injury 9/14/11, sustained while lifting heavy items. The treating physician report dated 10/22/14 (47) indicates that the patient presents with pain affecting the low back. The physical examination findings reveal grade 3 tenderness to palpation over the paraspinal muscles. There is restricted range of motion of the lumbar spine and a straight leg raise test is positive bilaterally. Prior treatment history per UR report dated 11/21/14 (31) includes 2 epidural steroid injections, Tramadol, Mobic, topical creams, and physical therapy. MRI findings of the lumbar spine per UR report dated 11/21/14 (31) reveal mild degenerative changes of the lumbar sacral spine, small focal central disc protrusion at the L5-S1 level slightly indenting the anterior border of the thecal sac without evidence of compression and conjoined nerve root sleeve associated with left L5 and S1 nerve roots. The current diagnoses are: 1. Lumbar musculoligamentous strain/sprain radiculitis 2. Lumbar spine disc herniation with radiculopathy. The utilization review reports dated 11/21/14 (6,14,23,31) denied the request for TGHOT 180gm, Tramadol 50mg x1 refill #60, Fluriflex 180gm, Decision for Additional PT once a week for 6 weeks based on a lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TGHOT 180gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

**Decision rationale:** The patient presents with pain affecting the low back. The current request is for TGHOT 180gm. TSHOT is a topical formulation of tramadol, gabapentin, menthol, camphor, and Capsaicin. The treating physician report dated 10/22/14 (48) states, "Topical medications were prescribed in order to minimize possible neurovascular complications; and to avoid complications associated with the use of narcotic medications, as well as upper GI bleeding from the use of NSAID's medications." MTUS has the following regarding topical creams: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, tramadol and gabapentin are not supported for topical formulation. The current request does not satisfy MTUS guidelines as outlined on pages 111-113. The request is not medically necessary.

**Tramadol 50mg x1 refill #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): 74-96.

**Decision rationale:** The patient presents with pain affecting the low back. The current request is for Tramadol 50mg x1 refill #60. The requesting treating physician report does not address or give any rationale regarding the current request for Tramadol. MTUS pages 88 and 89 states "document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS also requires documentation of the four A's (analgesia, ADL's, Adverse effects and Adverse behavior). After review of the sole progress report provided, it is unknown how long the patient has been taking Tramadol. A toxicology report dated 9/11/14 (40) notes that the patient tested positive for Tramadol. There is no discussion of Tramadol or a direct assessment of the patient's pain levels in any of the documents provided. In this case, no evidence of functional improvement has been documented and there are no records provided that document the patient's pain levels with and without medication usage and none of the required 4 A's are addressed. The MTUS guidelines require much more documentation to recommend continued opioid usage. The request is not medically necessary.

**Fluriflex 180gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

**Decision rationale:** The patient presents with pain affecting the low back. The current request is for Fluriflex 180gm. The treating physician report dated 10/22/14 (48) states, "Topical medications were prescribed in order to minimize possible neurovascular complications; and to avoid complications associated with the use of narcotic medications, as well as upper GI bleeding from the use of NSAID's medications." Fluriflex is a topical analgesic that contains 15% Flurbiprofen and 10% Cyclobenzaprine. MTUS has the following regarding topical creams: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS goes on to state that baclofen and other muscle relaxants are not recommended as a topical product. In this case, Cyclobenzaprine is a muscle relaxant and therefore is not recommend as a topical analgesic. The current request does not satisfy MTUS guidelines as outlined on pages 111-113. The request is not medically necessary.

**Additional PT once a week for 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

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

**Decision rationale:** The patient presents with pain affecting the low back. The current request is for Decision for Additional PT once a week for 6 weeks. The treating physician report dated 10/22/14 states, "The patient is to continue physical therapy for the lumbar spine, once per week for six weeks." There is only one treating physician report provided for review and there is no discussion or rationale regarding the current request for additional physical therapy. The patient has received prior physical therapy but the report provided does not specify an amount of visits that have been received. MTUS supports physical medicine (physical therapy and occupational therapy) 8-10 sessions for myalgia and neuritis type conditions. The MTUS guidelines only provide a total of 8-10 sessions over 4 weeks and the patient is expected to then continue on with a home exercise program. In this case, it is not clear how many prior physical therapy visits the patient has received and therefore it is uncertain if the request for an additional 6 visits exceeds the recommendation of 8-10. The current request does not satisfy the MTUS guidelines as outlined on pages 98-99. The request is not medically necessary.