

<b>Case Number:</b>	CM14-0200685		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	08/07/2010
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	11/19/2014
<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: New York

Certification(s)/Specialty: Neurological Surgery

### 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 45 year old male sustained an industrial injury on August 7, 2010. He reported constant pain in the neck, back and upper extremities including tingling and numbness in the hands and fingers. He was diagnosed with cervical sprain, displacement of thoracic or lumbar intervertebral disc without myelopathy, bilateral wrist sprain, pain in the hand joints, depression, chondromalacia patellae of the right knee and osteoarthritis. Treatment to date has included radiographic imaging, diagnostic studies, epidural steroid injections, psychotherapy, psychological evaluation, pain medications and lifestyle modifications. Many treatment modalities and conservative treatments have failed to provide more than temporary relief. On October 2014, the pain continued. Authorized requests have been submitted for Percocet 10/325, creams for pain and inflammation relief: TGIce (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%) and Flurbiprofen 20%, aquatic therapy 2 times a week for 6 weeks for lumbar spine, bilateral knees. Requests have also been made for electric scooter, narcotic test, neurological examination and treatment, transportation and home health services 2 times a week for 8 hours a day for 6 weeks. On November 19, 2014, Utilization Review non-certified a request for Percocet 10/325, Creams for pain and inflammation relief: TGIce (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%) and Flurbiprofen 20%, aquatic therapy 2 times a week for 6 weeks, lumbar spine, bilateral knees, electric scooter, narcotic test, neurological examination and treatment, transportation and home health services 2 times a week for 8 hours a day for 6 weeks noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On November 25, 2014, the injured worker submitted an application for IMR for review of Percocet 10/325, Creams for pain and

inflammation relief: TGIce (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%) and Flurbiprofen 20%, aquatic therapy 2 times a week for 6 weeks, lumbar spine, bilateral knees, electric scooter, narcotic test, neurological examination and treatment, transportation and home health services 2 times a week for 8 hours a day for 6 weeks.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Creams for pain and inflammation relief: TGIce (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%) and Flurbiprofen 20%: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical medications Page(s): 111. Decision based on Non-MTUS Citation Medications-compound drugs, topical, tramadol

**Decision rationale:** The California MTUS guidelines indicate that any compounded product that contains one drug that is not recommended is not recommended. The guidelines also indicate that their use requires specific knowledge on the analgesic effect of each agent and how it will be useful to attain a specific therapeutic goal. Documentation does not supply this evidence. The ODG guidelines note that topical Gabapentin is not recommended. They also note that the only NSAID which is FDA approved is diclofenac not fluriprofen. Thus the requested treatment: creams for pain and inflammation relief: TGLce(Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%) and Flurbiprofen 20% are not medically necessary or appropriate.

**Prove narcotic test:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 42.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): p.11, Chronic Pain Treatment Guidelines opioids, on going management Page(s): 94, 78.

**Decision rationale:** The California MTUS guidelines recommend for the worker an active health surveillance program. For the worker taking opioids they recommend frequent random urine toxicology screens especially if there are any red flags suggesting inappropriate behavior. In the ongoing management drug screens can be helpful in assessing compliance. The requested treatment prove narcotic test is medically appropriate and necessary.

**Percocet 10/325mg (unspecified): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids- Criteria for use Page(s): 76-80.

**Decision rationale:** The California MTUS guidelines note that use of opioids in the treatment of chronic back pain should be limited to the short term, less than two weeks. Documentation does not show adherence to this guideline. Percocet is a short acting drug with a 3-4 hours duration. The requested treatment does not list a frequency of dosage advised. The ODG guidelines do not advise opioids should be used for low back pain and note evidence of no advantage for opioids over NSAIDS. Thus the requested treatment: Percocet 10/325mg (unspecified) is not medically necessary or appropriate.

**Aquatic therapy 2 times a week for 6 weeks, lumbar spine, bilateral knees:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy and Physical Medicine Page(s): 22 and 99. Decision based on Non-MTUS Citation ODG, Low Back and Knee and Leg

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low back chapter-aquatic therapy, physical therapy

**Decision rationale:** The ODG guidelines note that 10 visits over 8 weeks can be recommended for workers with a lumbar sprain. The note that an aquatic program of 20 visits 5 times week for four weeks can be recommended. The requested treatment for aquatic therapy two times a week for six weeks, lumbar spine, bilateral knees does not meet these guidelines. Thus this requested treatment: Aquatic therapy 2 times a week for 6 weeks, lumbar spine, bilateral knees is not medically necessary or appropriate.

**Durable Medical Equipment purchase, electric scooter:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg, Power Mobility Devices (PMDs)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation knee chapter-power mobility devices

**Decision rationale:** The ODG guidelines do not recommend electric scooters for those whose functional mobility deficit can be sufficiently resolved with a cane or walker, or if the worker has upper extremity function to propel a manual wheelchair. Documentation shows the worker has this upper extremity strength. Moreover the goals of treatment for this worker are to promote exercise, mobilization and independence not foster dependency and illness. Thus the requested treatment: Durable Medical Equipment purchase, electric scooter is not medically necessary or appropriate.

**Neurosurgical consultation/ treatment:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Office Visits

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**Decision rationale:** The California MTUS guidelines note that surgical consultation is indicated if there is clear clinical, imaging and electrophysiological evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. Documentation does not provide this evidence, He only has bulging lumbar discs. The MTUS guidelines also note consultation is indicated if the worker had severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies. Documentation does not provide this evidence either. Moreover, his PR2 on 10/30/2013 noted he did have psychiatric clearance for surgery. Since he weighed 309 recommendation was for weight loss. Thus the requested treatment Neurosurgical consultation/treatment is not medically necessary or appropriate.

**Transportation services:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg, Transportation

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee Chapter-Transportation(to&from appointment)

**Decision rationale:** The ODG guidelines recommend medically-necessary transportation for appointments for patients with disabilities who are 55 and older and at a nursing home level of care. This worker is 45. No evidence is given that he is at a nursing home level of care. Thus the requested treatment: Transportation services is not medically necessary or appropriate.

**Home health services 2 times a week for 8 hours a day for 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee Chapter-Home health services

**Decision rationale:** ODG guidelines indicate home health services are recommended medical treatment for patients who are homebound. No documentation is provided that the worker is home bound. Moreover, the guidelines indicate medical treatment does not include homemaker services like laundry, shopping, or bathing or dressing. Thus the requested treatment of Home Health services 2 times a week for 8 hours a day for 6 weeks is not medically necessary or appropriate.