

<b>Case Number:</b>	CM15-0004033		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	12/16/2011
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	12/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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, Tennessee  
 Certification(s)/Specialty: Emergency Medicine

### 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 52 year old male, who sustained an industrial injury on 12/16/2011. He has reported subsequent back pain and was diagnosed with lumbar and thoracic sprain/strain. Treatment to date has included oral pain medication, application of heat and ice, rest and physical therapy. In a progress note dated 11/12/2014, the injured worker complained of back and neck pain. Objective physical examination findings were notable for tenderness to palpation of the lumbar and cervical spine. A request for authorization of topical creams, urine analysis for toxicology and compliance and 12 visits of physical therapy was made. On 12/24/2014, Utilization Review non-certified requests for topical creams and urine analysis for toxicology and compliance, noting that topical application of narcotics was not supported by guidelines and that confirmatory lab testing was not required and modified a request for physical therapy of the lumbar spine from 12 visits to 6 visits, noting that the request exceeded guidelines for an initial trial of physical therapy. MTUS and ODG guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy (12-sessions, twice a week for six weeks for the lumbar spine): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Therapy

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a 'six-visit clinical trial' to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. Recommended number of visits for myalgia and myositis is 9-10 visits over 8 weeks; and for neuralgia, neuritis, and radiculitis is 8-10 visits over 4 weeks. In this case the requested number of 12 visits surpasses the number of six recommended for clinical trial to determine functional improvement. The request should not be authorized.

**Topical Creams (unspecified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 13-15, 111-112. Decision based on Non-MTUS Citation UpToDate: Dextromethorphan: Drug information

**Decision rationale:** Review of the medical record shows that request was for two compounded topical analgesics. One medication contained flurbiprofen and tramadol and the other contained amitriptyline, dexamethorphan, and gabapentin. Topical analgesics are recommended for neuropathic pain when anticonvulsants and antidepressants have failed. Compounded topical analgesics are commonly prescribed and there is little to no research to support the use of these compounds. Furthermore, the guidelines state that: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen is a non-steroidal anti-inflammatory drug (NSAID). Flurbiprofen is recommended as an oral agent for the treatment of osteoarthritis and the treatment of mild to moderate pain. It is not recommended as a topical preparation. Tramadol is a synthetic opioid affecting the central nervous system. It has several side effects, which include increasing the risk of seizure in patients taking SSRIs, TCAs and other opioids. This medication contains drugs that are not recommended. Therefore the medication cannot be recommended. Regarding the second topical analgesic: Amitriptyline is a tricyclic antidepressant. Tricyclics are generally considered a first-

line agent for neuropathic pain, unless they are ineffective, poorly tolerated, or contraindicated. Indications in controlled trials have shown effectiveness in treating central post-stroke pain, post-herpetic neuralgia, painful diabetic and non-diabetic polyneuropathy, and post-mastectomy pain. It is not recommended as a topical medication. Dextromethorphan is an anti-tussive medication used to suppress cough. It is not recommended as a topical medication. Gabapentin is not recommended. There is no peer-reviewed literature to support use. This medication contains drugs that are not recommended. Therefore the medication cannot be recommended. The request should not be authorized.

**Urine Analysis for Toxicology and Compliance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Urine Drug Testing (UDT)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Urine Drug testing

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state that urinary drug testing should be used if there are issues of abuse, addiction, or pain control in patients being treated with opioids. ODG criteria for Urinary Drug testing are recommended for patients with chronic opioid use. Patients at low risk for addiction/aberrant behavior should be tested within 6 months of initiation of therapy and yearly thereafter. Those patients with moderate risk for addiction/aberrant behavior should undergo testing 2-3 times/year. Patients with high risk of addiction/aberrant behavior should be tested as often as once per month. In this case urine drug testing was ordered for the patient in August 2014. There is no documentation on aberrant/addiction behavior. Urine drug testing is indicated annually. There is no medical indication for repeat urine drug testing until August 2015. The request should not be authorized.