MAXIMUS Federal Services

Case Number:	CM15-0104131		
Date Assigned:	07/17/2015	Date of Injury:	10/24/2013
Decision Date:	08/20/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	06/01/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 56 year old male with an industrial injury 10/24/2013. The mechanism of injury is documented as pushing an aerator machine on a wet ground causing low back, knee, and wrist and ankle pain. His diagnoses included bilateral wrist/hand sprain, lumbosacral syndrome with sciatica, bilateral knee sprain/chondromalacia femoral condyles and bilateral ankle sprain. Prior treatment included home exercise program, physical therapy, chiropractic therapy and medications. He presents on 01/09/2015 with pain in right knee, left knee and bilateral ankles. Tenderness was noted to lumbar spine, bilateral wrists, bilateral knees, bilateral ankles and bilateral feet. Treatment recommendations at this time included pain creams, physical therapy and oral medications. He presents on 04/15/2015 with complaints of numbness and pain in bilateral wrists and hand. He also complained of low back pain radiating down to lower limbs with numbness and tingling in lower extremities. There was decreased range of motion as well as tenderness over his right wrist/hand with decreased range of motion. Lumbosacral spine exam showed decreased range of motion. Straight leg raise was positive. Left knee was tender with painful range of motion. The treatment request was for Flurbi (NAP) cream - LA (Flurbiprofen 20%/ lidocaine 5%/ amitriptyline 5%) 180 gm - (retrospective 1/9/15 and 3/31/15), Gabacyclotram (gabapentin 10%/ cyclobenzaprine 6%/ tramadol 10%), 180 gm - (retrospective 1/9/15 and 3/31/15), Motrin 800 mg quantity 60 (retrospective 1/9/15 and 3/31/15,) and Physical Therapy, 12 sessions - (retrospective 1/9/15 and 3/31/15). The request for Tylenol No 3, quantity 60 - (retrospective 1/9/15 and 3/31/15) was conditionally non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbi (NAP) cream - LA (flubiprofen 20%/ lidocaine 5%/ amitriptyline 5%) 180 gm - (retrospective 1/9/15 and 3/31/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Regarding the request for Flurbi (NAP) cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." Additionally, it is supported only as a dermal patch. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested Flurbi (NAP) cream is not medically necessary.

Gabacyclotram (gabapentin 10%/ cyclobenzaprine 6%/ tramadol 10%), 180 gm - (retrospective 1/9/15 and 3/31/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Regarding the request for gabacyclotram, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants and antiepilepsy drugs are not supported by the CA MTUS for topical use. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested gabacyclotram is not medically necessary.

Physical Therapy, 12 sessions - (retrospective 1/9/15 and 3/31/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99 of 127. Decision based on Non-MTUS Citation ODG, Pain Chapter, Physical Medicine.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

Motrin 800 mg Qty 60 (retrospective 1/9/15 and 3/31/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72 of 127.

Decision rationale: Regarding the request for Motrin, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Motrin is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Motrin is not medically necessary.