

Case Number:	CM15-0138519		
Date Assigned:	07/28/2015	Date of Injury:	07/21/2010
Decision Date:	08/25/2015	UR Denial Date:	06/20/2015
Priority:	Standard	Application Received:	07/16/2015

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: Preventive Medicine, Occupational 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 (IW) is a 39 year old male who sustained an industrial injury on 07/21/2010. He reported low back pain from continuous trauma. The injured worker was diagnosed as having: Lumbago, Lumbar disc protrusion, Lumbar facet dysfunction, Rule out right sacroiliac joint dysfunction. Treatment to date has included chiropractic care, physical therapy orthopedic care and medications. Currently, the injured worker complains of constant back pain in his lumbosacral area worse on the right. He rates his pain at a 3 on a scale of 1-10 on average and up to a 6 on the scale of 0-10 on aggravation. The pain is increased with prolonged walking, standing, and sitting. On exam, straight leg raising test was negative, facet loading test was positive, and strength was within normal limits. A MRI taken 10/08/2014 reveals a 4mm disc bulge with facet hypertrophy and lateral recess narrowing at L4-5 and L5-S1. The treatment plan of care includes medications, medication monitoring, and physical therapy with set-up of a home program to address stretching, strengthening, and core stabilization. A request for authorization was made for the following: 1. Compound Medication Flurbiprofen 10%, Lidocaine 10%, 2. 12 Physical therapy visits 3 times per week for 4 weeks for lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound Medication Flurbiprofen 10%, Lidocaine 10%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs section, Topical Analgesics Section Page(s): 67-73, 111-113.

Decision rationale: The MTUS Guidelines recommend the use of topical analgesics as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Topical NSAIDs, have been shown to be superior to placebo for 4-12 weeks for osteoarthritis of the knee. Topical flurbiprofen is not an FDA approved formulation. Topical lidocaine is used primarily for neuropathic pain when trials of antidepressant and anticonvulsants have failed. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. As at least one of the medications in the requested compounded medication is not recommended by the guidelines, the request for compound medication Flurbiprofen 10%, Lidocaine 10% is determined to not be medically necessary.

12 Physical therapy visits 3 times per week for 4 weeks for lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

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

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified, receive 9-10 visits over 8 weeks. In this case, the injured worker has completed 12 previous physical therapy sessions for the low back and should be well versed in continuing with a self-directed, home-based exercise program. Additionally, this request for 12 visits exceeds the guideline recommendations of 9-10 visits. The request for 12 Physical therapy visits 3 times per week for 4 weeks for lumbar spine is determined to not be medically necessary.