

<b>Case Number:</b>	CM15-0195384		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	11/19/2014
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	09/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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 36 year old male, who sustained an industrial injury on November 19, 2014. He reported sudden sharp pain in his mid and lower back shooting down both legs and abdominal pain and stiffness in his lower back and left leg. The injured worker was currently diagnosed as status post lumbar spine microdisectomy, lumbar spine disc space narrowing with spondylosis, bilateral lower extremity radiculopathy, cervical spine sprain and strain, bilateral shoulder sprain and strain, thoracic spine sprain and strain, abdominal sprain and strain, headaches, sleep disorder, sexual dysfunction and gastroesophageal reflux disease. Treatment to date has included diagnostic studies, medications, surgery, post-operative therapy without benefit, modified work duties, physical therapy without benefit and acupuncture treatment without benefit. A lumbar epidural injection relieved his pain for approximately one week. On July 31, 2015, the injured worker complained of continuous pain in the neck with radiation to his bilateral shoulder along with episodes of numbness and tingling. The neck pain is present 100% of the time. He rated the pain as a 7, on average, on a 1-10 pain scale. He complained of continuous pain in his bilateral shoulders radiating from the cervical spine and continuous pain in the mid back with radiation to his lower back. This pain is present 100% of the time and was rated as a 5-6 on the pain scale. He also reported continuous pain in the lower back with radiation to his bilateral lower extremities. This pain is present 100% of the time and is rated as a 5-6 on the pain scale. The injured worker also reported abdomen pain present 50% of the time. Medication was noted to help "relieve" his pain. The treatment plan included an updated lumbar spine MRI examination to rule out disc pathology, disc protrusion and stenosis. On September 3,

2015, utilization review denied a request for an interferential unit, Voltaren XR 100mg #30, Flurbiprofen 20% 120gm topical cream, Ketoprofen 20% 120gm-Ketamine 10% 120gm topical cream, Gabapentin 10%-Cyclobenzaprine 10%-Capsaicin 0.0375% 120gm topical cream and urine drug screen final confirmation.

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

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

**Interferential unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** Regarding the request for interferential unit, the Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. There is further stipulation that despite poor evidence to support use of this modality, patient selection criteria if interferential stimulation is to be used anyways include: pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement. The IMR process does have any provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.

**Voltaren XR 100mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** Regarding the request for this NSAID, 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 this medication is providing any specific analgesic benefits (in terms of percent

pain reduction, or reduction in numeric rating scale), or any objective functional improvement. This absence of documentation on efficacy is noted in the progress notes around the time of the Request for Authorization on 7/31/15, and also in the notes preceding this date. Given this, the current request is not medically necessary.

**Flurbiprofen 20% 120gm topical cream:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** This medication is a topical NSAID. Regarding the request for this topical NSAID, the Chronic Pain Medical Treatment Guidelines state that topical NSAIDs are recommended for short-term use of 4-12 week duration for body regions that are amenable to topical treatment. Specifically, the CPMTG state: "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." A review of the submitted medical records indicates that the primary use of this topical is for neck and low back pain, areas specifically not recommended for use due to scant evidence. There is also some shoulder pain, but this is not a recommended site for topical NSAIDs due to limited evidence. Given this, this request is not medically necessary.

**Ketoprofen 20%/Ketamine 10% 120gm topical cream:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** This compounded medication contains ketoprofen. The Chronic Pain Medical Treatment Guidelines on page 112 state the following: "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis. (Diaz, 2006) (Hindsen, 2006) Absorption of the drug depends on the base it is delivered in. (Gurol, 1996). Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. (Krummel 2000)" Within the submitted documentation, there is no explanation as to why the topical ketoprofen is prescribed despite MTUS recommendations against this formulation. It is not apparent if the worker has failed other forms of topical NSAIDs recommended by the CPMTG. Given this, this request is not medically necessary.

**Gapapentin 10%/Cyclobenzaprine 10% / Capsaicin 0.0375% 120gm topical cream:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** With regard to this request for a topical compounded cream that contains gabapentin as a component, the CPMTG does not recommend topical gabapentin. On page 113 of the Chronic Pain Medical Treatment Guidelines, the following is stated: "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." The guidelines further state that if one drug or drug class of a compounded formulation is not recommended, then the entire compounded formulation is not recommended. Therefore, the topical gabapentin component is not recommended, and the entire formulation is not medically necessary.

**Urine drug screen: final confirmation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing, Opioids, steps to avoid misuse/addiction. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

**Decision rationale:** Regarding the request for a urine toxicology test, CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option in patients on controlled substances. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. There risk stratification is an important component in assessing the necessity and frequency of urine drug testing. With the documentation available for review, there is no clear documentation of prescription of controlled substances. A progress note date 7/31/15 indicates that the patient is taking gabapentin, but does not make any mention of opioid prescription. Furthermore, no risk factor assessment, such as the utilization of the Opioid Risk Tool or SOAPP is apparent in the records, which would dictate the schedule of random periodic drug testing. Given this, this request is not medically necessary.