

Case Number:	CM15-0200065		
Date Assigned:	10/15/2015	Date of Injury:	05/10/2000
Decision Date:	11/18/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/12/2015

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
 Certification(s)/Specialty: Anesthesiology

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 50 year old male, who sustained an industrial injury on 5-10-2000. The injured worker is undergoing treatment for: lumbar sprain. On 7-27-15, he reported low back pain and stiffness with occasional pain and tingling in the right calf. Physical findings revealed tenderness with spasticity and limited range of motion to the lumbar spine, and equivocal straight leg raise testing bilaterally and negative lasegues, and normal reflexes of the patellar and Achilles bilaterally. There is notation of his having been in an automobile accident in March 2015, resulting in injury of the neck, back, and right leg. On 8-24-15 and 9-15-15, he reported low back pain. Objective findings revealed "tenderness, spasms, limited range of motion." The records do not indicate a current physical examination of the gastrointestinal system or report of gastrointestinal issues. There is no current discussion of the efficacy of medications prescribed or current functional status. The treatment and diagnostic testing to date has included: medication, physical therapy, pain management, lumbar epidural injections, TENS units. Medications have included: Vicodin, famotidine, metaxalone, and topical ointments. The records indicate he has been utilizing Ibuprofen, Flexeril, Prilosec, Flurbiprofen cream, and Ketoprofen cream since at least July 2015, possibly longer. Current work status: permanent and stationary. The request for authorization is for: one magnetic resonance imaging of the lumbar spine, Flexeril 7.5mg quantity 60 with 3 refills, Ibuprofen 800mg quantity 60 with 3 refills, Prilosec 20mg quantity 30 with 3 refills, Flurbiprofen 120gm quantity one tube with 3 refills compound, Ketoprofen 120gm quantity one tube with 3 refills. The UR dated 9-22-2015: non-certified the requests for one magnetic resonance imaging of the lumbar spine, Flexeril 7.5mg quantity 60 with 3 refills, Ibuprofen 800mg quantity 60 with 3 refills, Prilosec 20mg quantity 30 with 3 refills, Flurbiprofen 120gm quantity one tube with 3 refills compound, Ketoprofen 120gm quantity one tube with 3 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MRI.

Decision rationale: According to California MTUS Guidelines, MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication for a repeat MRI of the lumbar spine. The documentation indicates that the claimant had numerous MRI of the lumbar spine and since the last study in 2009, there are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no new neurologic findings on physical exam. Therefore, there is no specific indication for a repeat MRI of the lumbar spine. Medical necessity for the requested MRI has not been established. The requested imaging is not medically necessary.

Flexeril 7.5mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril), Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril), Muscle relaxants (for pain).

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system (CNS) depressant. It is closely related to the tricyclic anti-depressants. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. The medication has its greatest effect in the first four days of treatment. It is not recommended for the long-term treatment of chronic pain. In this case, there is no documentation of functional improvement from any previous use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Ibuprofen 800mg #60 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Motrin (Ibuprofen) is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, osteoarthritis, and acute exacerbations of chronic pain. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient has been on previous long-term NSAIDs without any documentation of significant improvement. Medical necessity of the requested medication, Motrin 800mg with 3 refills, has not been established. The request for this medication is not medically necessary.

Prilosec 20mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age > 65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. In this case, there is no documentation indicating that this patient had any GI symptoms or risk factors. In addition, the request for Ibuprofen was not found to be medically necessary, which would mean that the Omeprazole would not appear to be medically necessary for this patient. Medical necessity for Omeprazole is not established. The requested medication is not medically necessary.

Flurbiprofen 120gm #1 tube with 3 refills compound: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic compound is Flurbiprofen (120gm #1 tube with 3 refills). Flurbiprofen is not FDA approved for topical application. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Medical necessity for the requested item has not been established. The requested topical agent is not medically necessary.

Ketoprofen 120gm #1 tube with 3 refills compound: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or anti-depressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic requested is Ketoprofen (120gm #1 tube with 3 refills). Ketoprofen is not currently FDA approved for a topical application, and has an extremely high incidence of photo-contact dermatitis. Medical necessity for the requested topical analgesic medication has not been established. Medical necessity for topical Ketoprofen has not been established. The requested topical analgesic agent is not medically necessary.