

Case Number:	CM15-0206180		
Date Assigned:	10/23/2015	Date of Injury:	09/13/2011
Decision Date:	12/30/2015	UR Denial Date:	10/10/2015
Priority:	Standard	Application Received:	10/20/2015

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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, 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:

This is a 54 year old female with a date of injury of September 13, 2011. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar radiculopathy and lumbar facet syndrome. Medical records dated June 25, 2015 indicate that the injured worker complained of constant lower back pain radiating to the lower extremities rated at a level of 7 to 8 out of 10. A progress note dated August 6, 2015 documented complaints similar to those reported on June 25, 2015. Per the treating physician note on August 6, 2015, the employee was temporarily totally disabled. The physical exam dated June 25, 2015 reveals decreased range of motion of the lumbar spine, tenderness to palpation along the lumbar spine, tenderness to palpation of the paravertebral muscles bilaterally with spasms, positive straight leg raise bilaterally, antalgic gait, and decreased sensation to light touch of the lower extremities over the L5-S1 nerve root distribution bilaterally. The progress note dated August 6, 2015 documented a physical examination that showed decreased range of motion of the lumbar spine that was worse than shown on June 25, 2015, tenderness to palpation along the lumbar spine, positive straight leg raise on the left, positive Kemp's test bilaterally, and decreased sensation to light touch in the lower extremities along the L5-S1 nerve root distribution bilaterally. Treatment has included medications Cyclobenzaprine since at least April of 2015; Flurbiprofen cream, Gabapentin cream since May of 2015, Norco and home exercise program. Other medications listed include bupropion, Fioricet, Buspar and Lunesta. The utilization review (October 10, 2015) non-certified a request for Cyclobenzaprine 7.5mg #60, Flurbiprofen cream 240gm, Gabapentin cream 240gm,

Terocin patches #20, six month rental of a transcutaneous electrical nerve stimulator unit with supplies, and a second opinion with an orthopedic spine surgeon for the lumbar spine and knees.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Cyclobenzaprine hydrochloride 7.5mg, #60 (DOS: 08/06/2015): 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), Medications for chronic pain, Muscle relaxants (for pain), Weaning of Medications. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain ChapterMuscle Relaxants.

Decision rationale: The CA MTUS and the ODG guidelines recommend that muscle relaxants can be utilized for the short-term treatment of exacerbation of musculoskeletal pain that did not respond to standard treatment with NSAIDs, exercise and PT. The chronic use of muscle relaxants can be associated with the development of tolerance, dependency, addiction and adverse interaction with opioids or sedative medications. There is lack of guidelines support for the utilization of topical formulations of cyclobenzaprine. The records indicate that the duration of utilization of cyclobenzaprine had exceeded the maximum guidelines recommended period of 4 to 6 weeks. The criteria for Retrospective use of Cyclobenzaprine hydrochloride 7.5mg #60 DOS 8/6/2015 was not met. Therefore, the request is not medically necessary.

Flurbiprofen cream 240gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, hypertension and renal function, NSAIDs, specific drug list & adverse effects, Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain ChapterNSAIDs.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics can be utilized for the treatment of localized neuropathic pain extremities mono joint pain when standard treatment with orally administered NSAIDs, anticonvulsant and antidepressant medications are not effective. The records indicate that the subjective and objective findings are not consistent with a diagnosis of mono extremity joint pain or localized neuropathic pain such as CRPS. The chronic use of topical analgesics can be associated with the development of tolerance and decreased efficacy compared with orally administered NSAIDs. The records did not show that treatment with orally administered first line NSAIDs, anticonvulsant and antidepressant medications. The criteria for the utilization of topical formulations of criteria for the use of Flurbiprofen cream 240mg was not met. Therefore, the request is not medically necessary.

Gabapentin cream 240gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs), Medications for chronic pain, Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Anticonvulsant.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics can be utilized for the treatment of localized neuropathic pain when standard treatment with orally administered NSAIDs, anticonvulsant and antidepressant medications are not effective. The subjective and objective findings are not consistent with a diagnosis of mono extremity joint pain or localized neuropathic pain such as CRPS. The chronic use of topical analgesics is associated with the development of tolerance and decreased efficacy compared with orally administered analgesics. There is lack of guidelines support for the use of orally administered first line anticonvulsant and antidepressant medications. The criteria for the use of Gabapentin cream 240mg was not met. The request is not medically necessary.

Terocin pain patch, #20: 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): Medications for chronic pain, Nonprescription medications, Salicylate topicals, Topical Analgesics.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics can be utilized for the treatment of localized neuropathic pain / extremities mono joint pain when standard treatment with orally administered NSAIDs, anticonvulsant and antidepressant medications are not effective. The subjective and objective findings are not consistent with a diagnosis of mono extremity joint pain or localized neuropathic pain such as CRPS. The Terocin product contains menthol 10% / lidocaine 2.5% / capsaicin 0.025% / methyl salicylate chronic use of topical NSAIDs is associated 25%. There is lack of guidelines support for the use of menthol and methyl salicylate for the treatment of chronic musculoskeletal pain. The records did not show that treatment with orally administered first line anticonvulsant and antidepressant medications. The criteria for the use of Terocin pain patch #20 was not met. The request is not medically necessary.

Transcutaneous electrical nerve stimulation (TENS) unit with supplies, 6 month rental: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim), Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain ChapterTENS.

Decision rationale: The CA MTUS and the ODG guidelines recommend that transcutaneous electrical nerve stimulator (TEN) can be utilized for the treatment of neuropathic and musculoskeletal pain. The use of TENS can result in reduction in pain, decrease in medication utilization and functional restoration. The records indicate that the pain had not been well controlled with conservative treatment with medications and home exercise program. The subjective and objective findings are consistent with the neuropathic and musculoskeletal pain. The criteria for the use of Transcutaneous electrical nerve stimulator (TENS) unit with supplies, 6 months rental was met. The request is medically necessary.

Second opinion with orthopedic surgeon for the lumbar spine and the knees: Overturned

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Follow-up Visits, Surgical Considerations, and Knee Complaints 2004, Section(s): Surgical Considerations, Follow-up Visits, References. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain ChapterLow BackKnee.

Decision rationale: The CA MTUS and the ODG guidelines recommend that patients can be referred for evaluation and treatment by a specialist when the diagnosis is complex or additional expertise treatment had become necessary in patients who are non responsive to standard treatment. The records indicate that the subjective and objective findings had not improved despite conservative treatments with medications and physical therapy / home exercise program. The MRI reports show radiological findings that can be amenable to surgical treatments. The criteria for the second opinion with orthopedic surgeon for the lumbar spine and the knees has been met and the request is medically necessary.