MAXIMUS Federal Services

Case Number:	CM15-0032697		
Date Assigned:	02/26/2015	Date of Injury:	12/01/2006
Decision Date:	04/07/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	02/20/2015

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: Maryland
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 is a 46 year old male, who sustained an industrial injury on December 1, 2006. He has reported lower back pain and left leg pain. The diagnoses have included chronic lower back pain, psuedoarthrosis, lumbar spine disc protrusions, and medication induced gastritis. Treatment to date has included medications, lumbar spine transforaminal epidural steroid injection, lumbar spine fusion, and imaging studies. A progress note dated January 9, 2015 indicates a chief complaint of continued lower back pain with left leg pain. Physical examination showed muscle tenderness of the cervical spine, bilateral cervical spine facet tenderness, lumbar spine tenderness, and mild weakness of the left leg secondary to pain.
The treating physician requested physical therapy, acupuncture, durable medical equipment, and prescriptions for Prilosec, Trazodone, Colace, Flurido cream, Ultraflex C cream, and Ultracin topical cream. On February 9, 2015 Utilization Review denied the request citing the California Medical Treatment Utilization Schedule California Chronic Pain Medical treatment Guidelines. On February 20, 2015, the injured worker submitted an application for IMR of a request for physical therapy, acupuncture, durable medical equipment, and prescriptions for Prilosec, Trazodone, Colace, Flurido cream, Ultraflex C cream, and Ultracin topical cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20 mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI Symptoms & Cardiovascular Risks.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Prilosec 20 mg #60 is medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that the patient is at risk for gastrointestinal events if they meet the following criteria (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The guidelines also state that a proton pump inhibitor can be considered if the patient has NSAID induced dyspepsia. The documentation indicates a history of heartburn, prior history of GI bleed on NSAIDs, and gastritis. The request for Prilosec is medically necessary.

Trazodone 50 mg HS 3 (QTY: not Specified): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 11th Edition, Web; Mental Illness and Stress, Trazodone (Desyral.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental illness and stress-Trazodone (Desyrel).

Decision rationale: Trazodone 50 mg HS 3 (QTY: not Specified) is not medically necessary per the ODG. The MTUS does not address this request. The ODG states that Trazodone is not recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. The documentation does not indicate evidence of functional improvement on prior Trazadone therefore this request is not medically necessary.

Colace 100mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid therapy, treatment of Constipation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web) 2014; Opioid Induced Constipation Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Initiating Therapy Page(s): 77.

Decision rationale: Colace 100mg #60 is medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The patient was certified opioids on 12/1/14. The MTUS

supports prophylaxis against opioid induced constipation. The request for Colace is medically necessary.

Flurido Cream Apply BID (Strength and QTY: not Specified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

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

Decision rationale: Flurido Cream Apply BID (Strength and QTY: not Specified) is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines indicate that topical formulations of lidocaine (whether creams, lotions or gels) are not indicated for neuropathic pain. The guidelines state that topical NSAIDs are indicated in 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. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). There is little to no research to support the use of many of these agents. The MTUS does not indicate evidence of support for topical Amitryptline. The documentation does not indicate intolerance to oral medications. The guidelines additionally add that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical Lidocaine is not recommended by the MTUS. The request does not specify a strength or quantity. Therefore, the request for Flurido cream is not medically necessary.

Ultraflex C Cream BID (Strength and QTY: not Specified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111.

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

Decision rationale: Ultraflex C Cream BID (Strength and QTY: not Specified) is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The request does not indicate a strength or quantity. The documentation does not indicate intolerace to oral medications. The request for Ultraflex C is not medically necessary.

Ultracin Topical Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111.

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

Decision rationale: Ultracin Topical Cream is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. Ultracin contains methyl salicylate; menthol, Capsaicin. The MTUS does support topical salicylate (e.g., Ben-Gay, methyl salicylate) and states that this is significantly better than placebo in chronic pain. The guidelines state that Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. The documentation does not indicate functional improvement on prior Ultracin. The request does not specify a quantity. The patient is not intolerant to oral medications. The request is not medically necessary.

Physical Therapy (Qty: not Specified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

Decision rationale: Physical Therapy (Qty: not Specified) is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS recommends transition to an independent home exercise program. The request as written does not specify a body part. The documentation is not clear on the amount of prior therapy and there is no documentation of functional improvement from prior therapy. The request does not specify a quantity. The request for physical therapy is not medically necessary.

Acupuncture (QTY: not Specified): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Acupuncture (QTY: not Specified) is not medically necessary per the MTUS Acupuncture Guidelines. The MTUS states that the time to produce functional improvement for acupuncture is 3 to 6 treatments at a frequency: 1 to 3 times per week with a duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20. The documentation indicates that the patient has had prior acupuncture but there is no objective documentation of functional improvement. Additionally, it is not clear how much prior acupuncture the patient has had and the request does not specify a quantity. The request for acupuncture is not medically necessary.

Durable Medical Equipment (Not Specified): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index (web) 2014; Knee and leg, Durable Medical Equipment (DME).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg-Durable medical equipment.

Decision rationale: Durable Medical Equipment (Not Specified) is not medically necessary per the ODG. The MTUS does not address this issue. The ODG states the term DME is defined as equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; & is appropriate for use in a patient's home. The request does not specify what DME is requested therefore this request is not medically necessary.