

Case Number:	CM14-0133177		
Date Assigned:	09/08/2014	Date of Injury:	03/11/2014
Decision Date:	10/14/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/20/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 records presented for review indicate that this 44-year-old gentleman was reportedly injured on March 11, 2014. The mechanism of injury is noted as lifting a heavy patient. The most recent progress note, dated July 8, 2014, indicates that there were ongoing complaints of lower back pain radiating to the left lower extremity. Some improvement has been noted with physical therapy. Current medications include Norco, Celebrex, Prozac, Lipitor, Pepcid, and Omeprazole. The physical examination demonstrated the presence of an antalgic gait. There was tenderness and spasms along the lumbar spine paraspinal muscles and decreased range of motion. There was a positive left and right sided straight leg raise test. Neurological testing noted decreased sensation at the posterior lateral foot and heel, a decreased left sided ankle jerk, and decreased plantar strength on the left side. Diagnostic nerve conduction testing indicated a left-sided L5 and S1 radiculopathy. A magnetic resonance imaging (MRI) of the lumbar spine showed disk space collapse and L5 - S1 with annular tearing. Previous treatment includes physical therapy, acupuncture, a lumbar spine epidural steroid injection, and oral medications. A request had been made for Prozac, Fluriflex, and TG Hot and was not certified in the pre-authorization process on July 17, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prozac 20mg every morning with two refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants. Decision based on Non-MTUS Citation <http://www.drugs.com/prozac.html>

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 13-16 & 107 of 127..

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) notes that selective serotonin reuptake inhibitors are not recommended for the treatment of chronic pain, but may be beneficial for the treatment of psychosocial symptoms associated with chronic pain. Based on the clinical documentation provided, there is not a diagnosis of anxiety or depression. As such, this request for Prozac is not medically necessary.

Fluriflex (Flurbiprofen/Cyclobenzaprine 15/10%) cream 240grams to be applied to the affected area twice daily: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Topical Analgesics

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 111-112 of 127.

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines, the only topical analgesic medications indicated for usage include anti-inflammatories, lidocaine, and capsaicin. There is no known efficacy of any other topical agents. California Medical Treatment Utilization Schedule (MTUS), when one component of a product is not necessary the entire product is not medically necessary. Considering this, the request for Fluriflex is not medically necessary.

TGHot (Tramadol/Gababentin/Menthol/Camphor/Capsaicin 8/10/22/.05%) cream 240 grams to be applied to the affected area twice daily: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 111-112 of 127.

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines, the only topical analgesic medications indicated for usage include anti-inflammatories, lidocaine, and capsaicin. There is no known efficacy of any other topical agents. Per California Medical Treatment Utilization Schedule (MTUS), when one component of a product is not necessary the entire product is not medically necessary. Considering this, the request for TG Hot is not medically necessary.