MAXIMUS Federal Services

Case Number:	CM14-0106893		
Date Assigned:	07/30/2014	Date of Injury:	09/23/2010
Decision Date:	04/22/2015	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	07/10/2014

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. 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

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 42 year old female with an industrial injury dated 08/27/2008 to 12/14/2010; 09/23/2010. The injured worker stated that on 09/23/2010 she slipped and fell with immediate onset of pain in her neck and back. She states a few minutes later her left leg gave out on her and she fell forward onto her hands and knees aggravating her neck and back pain and injuring her right shoulder and hand. She states she was examined, x-rays were taken and medication was prescribed. Treatments to date include, physical therapy, home exercises, evaluation by a chiropractor, MRI and medications. She presented on 05/08/2014 with complaints of low back pain rated as 4/10. Physical exam noted tenderness to palpation and restricted range of motion of lumbar spine. Diagnosis included history of lumbosacral spine disc protrusion, sleep disturbance secondary to pain and situational depression. The provider requested pain medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #90 Q6 hrs PRN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 111, 74-95.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: This patient has a date of injury of 09/23/10 and presents with complaints of knee and low back pain. The Request for Authorization is not provided in the medical file. The current request is for TRAMADOL 50MG #90 Q6 HRS PRN. For chronic opiate use, the MTUS guidelines pages 88 and 89 states: Pain should be assessed at each visit and function should be measured at 6-month intervals using a numerical scale or validated instrument. The MTUS page 78 also requires documentation of the 4 A's, which includes analgesia, ADLs, adverse side effects, and aberrant behavior. MTUS also requires pain assessment or outcome measures that include current pain, average pain, least pain; intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. The medical file provided for review includes two-progress report dated 05/08/14 and 03/05/14 and a QME report dated 09/16/13. According to progress report dated 03/05/14, the patient was utilizing an over the counter analgesic with worsening of pain. Tramadol was dispensed on this date and a refill was provided on 05/08/14. In this case, recommendation for further use cannot be supported as the treating physician has not provided any specific functional improvement, changes in ADL's or change in work status to document significant functional improvement with utilizing long term opiate. There are no before and after pain scales provided to denote a decrease in pain with utilizing long-term opioid. Furthermore, there are no discussions regarding aberrant behaviors or adverse side effects as required by MTUS for opiate management. The treating physician has failed to provide the minimum requirements as required by MTUS for opiate management. This request IS NOT medically necessary and recommendation is for slow weaning per MTUS.

Fluriflex: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 74-95, 111.

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

Decision rationale: This patient has a date of injury of 09/23/10 and presents with complaints of knee and low back pain. The Request for Authorization is not provided in the medical file. The current request is for FLURIFLEX. Fluriflex cream includes Flurbiprofen and cyclobenzaprine. The MTUS Guidelines p 111 has the following regarding topical creams, topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety. For Flurbiprofen, MTUS states, "the efficacy in clinical trials for this treatment modality has been inconsistent, and most studies are small and of short duration. Topical NSAIDs had been shown in the meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. Indications for use are osteoarthritis and tendinitis (in particular, that of the knee and elbow) or other joints that are amendable to topical treatment. In this case, the patient does meets the indication for the use of a topical NSAID, but Cyclobenzaprine is a muscle relaxant and is not recommended for any topical formulation. MTUS Chronic Pain Medical Treatment Guidelines page 111 through 113 under topical analgesic state: Any compounded product that

contains at least 1 drug or drug class that is not recommended is not recommended. This request IS NOT medically necessary.