

Case Number:	CM15-0002679		
Date Assigned:	01/13/2015	Date of Injury:	09/02/2014
Decision Date:	03/10/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	01/06/2015

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: Pennsylvania
 Certification(s)/Specialty: Internal 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 42 year old male who sustained an industrial injury on 9/2/2014. He has reported lumber pull and pain associated with sharp pain, stiffness and difficulty walking. The diagnoses have included lumbago, lumbar myospasm, and lumbar musculoligamentous sprain/strain. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), pain medication, muscle relaxant and physical therapy. Currently, the injured worker complains of pain in lower back, bilateral lower extremities, and sciatica rating 5-6/10 on the visual analog scale that is relieved with medication and physical therapy. Physical examination documented tenderness and spasm on paraspinal muscles bilaterally and bilateral sacroiliac tenderness. Medications as of 10/14/14 included ketoprofen tablets, protonix, flexeril, ultram, and topical creams. The documentation indicates a request for a transcutaneous electrical nerve stimulation (TENS) unit and a hot/cold unit. Work status was temporarily totally disabled. On 12/4/2014 Utilization Review non-certified NPCI Gabapentin 10%/Amitriptyline 10%/Bupivacaine 5% in cream base 210 GMS #1, MPCFI Flurbiprofen 20%/Baclofen 10%/Dexamethasone 2% in cream base 210 GMS #1, Multi Slim Unit, and hot/cold unit. Utilization Review modified certification for Flexeril 7.5mg #60 to #30, noting the allowance for a weaning process of the medication. The MTUS Chronic Pain Medical Treatment Guidelines were cited by Utilization Review. This Utilization Review (UR) decision was subsequently appealed to Independent Medical Review (IMR).

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 7.5. sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain) Section Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants p. 63-66cyclobenzaprine p. 41-42 Page(s): p. 41-42, 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. The duration of pain symptoms in this injured worker suggests subacute to chronic low back pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. The documentation indicates multiple additional medications have been prescribed. Limited, mixed evidence does not allow for a recommendation for chronic use. The quantity prescribed implies long term use, not for a short period of use for acute pain. The request for flexeril 7.5 mg #60 is not medically necessary.

NPCI Gabapentin 10%/Amitriptyline 10%/Bupivacaine 5% in cream base, 210 grams:
Upheld

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

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

Decision rationale: Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of trial of antidepressant or anticonvulsant medication for this injured worker, and the injured worker does not have a diagnosis of neuropathic pain. Topical gabapentin is not recommended by the MTUS. Per the MTUS, if any compounded product contains at least one drug that is not recommended, the compounded product is not recommended. As the compound contains gabapentin, which is not recommended, the compound is not recommended. The request for Gabapentin 10%/Amitriptyline 10%/ Bupivacaine 5% in cream base 210 GMS #1 is not medically necessary.

MPCI Flurbiprofen 20%/Baclofen 10%/Dexamethasone 2% in a cream base, 210 grams:
Upheld

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

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

Decision rationale: Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of trial of antidepressant or anticonvulsant medication for this injured worker, and the injured worker does not have a diagnosis of neuropathic pain. Per the MTUS, if any compounded product contains at least one drug that is not recommended, the compounded product is not recommended. Topical baclofen is not recommended. As this compound contains baclofen, which is not recommended in topical form, the compounded product is not recommended. Per the MTUS, topical nonsteroidal anti-inflammatory medications (NSAIDs) for short term pain relief may be indicated for pain in the extremities caused by osteoarthritis or tendonitis. There is no good evidence supporting topical NSAIDs for shoulder or axial pain. The injured worker does not have a diagnosis of osteoarthritis or tendinitis. There should be no concurrent use of an oral and topical NSAID. The injured worker has been concurrently prescribed flurbiprofen (a NSAID) topically, and ketoprofen tablets, an oral NSAID, making therapy duplicative and potentially toxic. The only FDA approved topical NSAID is voltaren gel (diclofenac). For these reasons, the request for MPC1 Flurbiprofen 20%/Baclofen 10%/Dexamethasone 2% in cream base 210 GMS #1 is not medically necessary.

A multi-stim unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (ICS) Section Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy Page(s): p. 114-121.

Decision rationale: The physician documentation indicates the request for multi-stim unit was for a transcutaneous electrical nerve stimulation (TENS) unit; however, the Multi-stim unit includes TENS, interferential, and neuromuscular stimulation. The MTUS specifies that TENS is not recommended as a primary modality but a one-month home based TENS trial may be considered if used as an adjunct to a program of evidence-based functional restoration for certain conditions, including neuropathic pain, complex regional pain syndrome, phantom limb pain, spasticity in spinal cord injury, multiple sclerosis, and acute post-operative pain. None of these diagnoses have been documented for this injured worker, whose diagnoses include lumbago, lumbar myospasm, and lumbar musculoligamentous sprain/strain. A treatment plan with the specific short and long term goals of treatment with the TENS unit should be submitted; in this case, no treatment plan/goals of treatment were submitted. Neuromuscular stimulation is not recommended outside of the post-stroke rehabilitative context and there is no evidence to support its use in chronic pain. The injured worker does not have a diagnosis of stroke. Per the MTUS, interferential current stimulation is not recommended as an isolated intervention. If certain criteria are met, a one month trial may be appropriate to permit the physician and physical medicine provider to determine effects and benefits. Criteria include pain which is ineffectively controlled by medications, history of substance abuse, pain from postoperative conditions that

limit the ability to perform exercise programs, or lack of response to conservative measures. None of these criteria are in evidence for this injured worker. The request for Multi stim unit is not medically necessary.

Hot/Cold Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): table 12-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): p. 299, 308. Decision based on Non-MTUS Citation low back chapter: heat therapy

Decision rationale: Per the ACOEM low back chapter, at-home applications of heat or cold may be used for symptom control for low back complaints. Per the ODG, heat therapy is recommended as an option for treating low back pain. Both the MTUS and ODG recommend at-home local applications of cold packs in the first few days of acute complaint and thereafter applications of heat packs or cold packs. There is no recommendation for any specific device in order to accomplish this. There was lack of documentation to indicate the frequency of use of the device, and no end point to use was specified. In addition, there was no documentation as to why at-home application of hot or cold packs would be insufficient. For these reasons, the request for hot/cold therapy unit is not medically necessary.