

<b>Case Number:</b>	CM15-0099127		
<b>Date Assigned:</b>	06/01/2015	<b>Date of Injury:</b>	02/17/2006
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	04/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2015

### 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: New York

Certification(s)/Specialty: Pediatrics, 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 56 year old male, who sustained an industrial injury on 2/17/06. The injured worker was diagnosed as having acute exacerbation of L3-L4 radiculitis, lumbar spine myofascial pain syndrome, L3-L4 left lateral disc protrusion with severe neural foraminal stenosis, left lower extremity radiculopathy at L3-4, status post left sided L3-4 revision decompression, anxiety and depression, status post AP fusion 360 degrees, transition syndrome at L3-4 and status post posterior lumbar revision interlaminar laminotomy at L3-4. Treatment to date has included oral medications including Norco, Ultram, Zanaflex, Neurontin and Omeprazole, physical therapy, cane for ambulation, lumbar brace and topical creams. Currently, the injured worker complains of constant and moderately severe low back pain rated 8/10 with radiation to bilateral lower extremities with associated numbness and tingling sensation. He also complains of constant and mild right wrist and hand pain rated 3/10 with radiation to the right upper extremity with associated numbness and tingling sensation. He notes physical therapy is helping. He is currently not working. He states 50% symptomatic pain relief with medications. A urine drug screen was performed. Physical exam noted restricted range of motion of lumbar spine with well healed lumbar incision; slight weakness at the lower extremities and slow and guarded gait. A request for authorization was submitted for aquatic therapy and prescriptions for Prilosec, Neurontin, Flexeril, Ultram, Norco and Flurbiprofen cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continue Aquatic Therapy (frequency unspecified): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Aquatic therapy.

**Decision rationale:** Per ODG guidelines, aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. There may be advantages to weightless running in back pain recovery. The documentation provided shows that aquatic therapy was approved on April 15, 2015 for twice a week for 4 weeks. There were no reports regarding how many of those therapy sessions that have occurred nor the therapy provided and if there was any functional benefit. The request is not medically necessary.

**Prilosec 20mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & cardiovascular risk.

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

**Decision rationale:** The indication for proton pump inhibitor use is intermediate or high risk of GI side effects. According to MTUS guidelines, it is necessary to determine if the patient is at risk for gastrointestinal events. Risk factors are: (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). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. There are no notations of risk factors for GI side effects in the progress notes. This request is not medically necessary and appropriate.

**Flexeril 10mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain)/Antispasmodic.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

**Decision rationale:** Muscle relaxants are recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. The greatest effect appears to be in the first 4 days of treatment. The documentation does not reference any muscle spasm that the Flexeril would be used for and at this time frame it is not indicated. This request is not medically necessary and appropriate.

**Flurbiprofen 20% cream 120gm:** Upheld

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

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

**Decision rationale:** Topical NSAID's are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen is not FDA approved for topical use. This request is not medically necessary and appropriate.

**Ketoprofen 20%, Ketamine 10% cream 120gm:** Upheld

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

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

**Decision rationale:** Topical NSAID's are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Ketoprofen is not FDA approved for topical use. The use of topical ketamine is currently under study and is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. These requests are not medically necessary and appropriate.

**Gabapentin 10%; Cyclobenzaprine 10%; Capsaicin 0.0375% cream 120gm:** Upheld

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

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

**Decision rationale:** According to MTUS guidelines, Capsaicin is approved for topical use in patients who are intolerant to other treatments. Cyclobenzaprine and gabapentin are not FDA

approved for topical use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. This request is not medically necessary and appropriate.

**Urine Drug Screen final confirmation results:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, pain treatment agreement Page(s): 89.

**Decision rationale:** According to MTUS guidelines, IW's treated with opioids may be required to sign a pain treatment agreement. Part of the agreement may include urine screening for medication and illicit substances. No pain management agreement was submitted stating urinalysis was required and there was no notation of irregular behavior suggesting abuse. This request is not medically necessary and appropriate.