
Notice of Independent Medical Review Determination

Dated: 11/7/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/10/2013
Date of Injury: 2/23/2004
IMR Application Received: 7/26/2013
MAXIMUS Case Number: CM13-0003617

- 1) MAXIMUS Federal Services, Inc. has determined the request for Hydrocodone/APAP 10/325mg #60 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Cyclobenzaprine 7.5mg #60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Fluiflex (Flurbiprofen/Cyclobenzaprine 15/10%) cream 180gm **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for TG Hot (Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/.5%) cream 180gm **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for total hip replacement, 2 day inpatient stay, post op physical therapy left hip times 12 to start one month after surgery **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/2/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for Hydrocodone/APAP 10/325mg #60 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Cyclobenzaprine 7.5mg #60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Fluiiflex (Flurbiprofen/Cyclobenzaprine 15/10%) cream 180gm **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for TG Hot (Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/.5%) cream 180gm **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for total hip replacement, 2 day inpatient stay, post op physical therapy left hip times 12 to start one month after surgery **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology and is licensed to practice in California. 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 10, 2013

Clinical Rationale

The patient is a 53 year old male with a date of injury of 2/23/2004. The provider has submitted a prospective request for one prescription of ibuprofen 800mg #90, one prescription of hydrocodone/APAP

10/325mg #60, one prescription of cyclobenzaprine 7.5mg #60, one prescription of Fluriflex (Flurbiprofen/cyclobenzaprine 15/10%) cream 180gm, and one prescription of TG Hot (tramadol/gabapentin/menthol/camphor/capsaicin 8/10/2/.05%) cream 180gm.

According to documentation submitted, the patient is currently being treated for persistent low back and hip pain. Objective findings on 6/14/2013 consisted of a scissor gait, spasm and tenderness of the paralumbar musculature, limited lumbar ranges of motion, and severely reduced left hip internal and external rotation with instability. The patient was diagnosed with cerebrovascular accident, significant spinal sprain/strain syndrome, lumbar discopathy, left-sided sciatica, left hip arthritis, right shoulder contusion, and possible rotator cuff injury. The provider is requesting a prescription of ibuprofen at this time.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review (received 7/25/2013)
- Utilization Review Determination from [REDACTED] (dated 7/9/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

1) Regarding the request for Hydrocodone/APAP 10/325mg #60:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical treatment Guidelines (2009), Opioids for Chronic Pain section, which is part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), Opioids, pg. 74-82, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee has a date of injury of 2/23/2004. A review of the submitted records indicates the employee is currently being treated for persistent low back and hip pain. Objective findings on 6/14/2013 consisted of a scissor gait, spasm and tenderness of the paralumbar musculature, limited lumbar ranges of motion, and severely reduced left hip internal and external rotation with instability. The employee was diagnosed with cerebrovascular accident, significant spinal sprain/strain syndrome, lumbar discopathy, left-sided sciatica, left hip arthritis, right shoulder contusion, and possible rotator cuff injury. The medical records submitted provided for review indicate treatments have included medications. A request for Hydrocodone/APAP 10/325mg #60 was submitted.

The Chronic Pain Medical Treatment Guidelines state short-acting opioids such as hydrocodone are an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain and the duration of action is generally 3 to 4 hours. The use of opioids should be part of a treatment plan that is tailored to the patient. A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and

functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be noted for the use of ongoing opioid management. Opioids should be discontinued if there is no overall improvement in function unless there are extenuating circumstances. As per the clinical notes submitted, there is no indication of a failure of first-line therapy with non-opioid analgesics prior to the request for an opioid. There is also no ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects following the use of this medication. California Guidelines state satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Opioids should only be continued if the patient has returned to work or if the patient has improved functioning and pain. Based on the clinical information received for this review, the ongoing use of an opioid is not medically appropriate at this time. **The request for Hydrocodone/APAP 10/325mg #60 is not medically necessary and appropriate.**

2) Regarding the request for Cyclobenzaprine 7.5mg #60:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics section, which is part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), pages 63-66, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee has a date of injury of 2/23/2004. A review of the submitted records indicates the employee is currently being treated for persistent low back and hip pain. Objective findings on 6/14/2013 consisted of a scissor gait, spasm and tenderness of the paralumbar musculature, limited lumbar ranges of motion, and severely reduced left hip internal and external rotation with instability. The employee was diagnosed with cerebrovascular accident, significant spinal sprain/strain syndrome, lumbar discopathy, left-sided sciatica, left hip arthritis, right shoulder contusion, and possible rotator cuff injury. The medical records submitted provided for review indicate treatments have included medications. A request for Cyclobenzaprine 7.5mg #60 was submitted.

Chronic Pain Medical Treatment Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Antispasmodics are used to decrease muscle spasm in conditions such as low back pain. Cyclobenzaprine is recommended for a short course of therapy. This medication is not recommended to be used for longer than 2 to 3 weeks. As per the clinical information submitted, the employee was initially prescribed cyclobenzaprine 7.5 mg #60 on 03/18/2013. Therefore, the employee is well beyond the recommended duration of 2 to 3 weeks. Additionally noted, there is no evidence provided of this employee's trial of first-line therapy prior to the request for an

antispasmodic for muscle spasms. **The request for Cyclobenzaprine 7.5mg #60 is not medically necessary and appropriate.**

3) Regarding the request for Fluiflex (Flurbiprofen /Cyclobenzaprine 15/10%) cream 180gm:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics section and Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) section, which is part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), pages 111-113, Topical Analgesics, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee has a date of injury of 2/23/2004. A review of the submitted records indicates the employee is currently being treated for persistent low back and hip pain. Objective findings on 6/14/2013 consisted of a scissor gait, spasm and tenderness of the paralumbar musculature, limited lumbar ranges of motion, and severely reduced left hip internal and external rotation with instability. The employee was diagnosed with cerebrovascular accident, significant spinal sprain/strain syndrome, lumbar discopathy, left-sided sciatica, left hip arthritis, right shoulder contusion, and possible rotator cuff injury. The medical records submitted provided for review indicate treatments have included medications. A request for Fluiflex (Flurbiprofen/Cyclobenzaprine 15/10%) cream 180gm was submitted.

Chronic Pain Medical Treatment Guideline recommends topical analgesics as an option. They are largely experimental in use and primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical NSAIDs have been shown to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. Indications for topical NSAID include osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. Recommended use includes 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. The only FDA-approved NSAID for topical use includes Voltaren or diclofenac which is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip, or shoulder. There is also no evidence for use of any other muscle relaxant as a topical product. As per the clinical notes submitted, there is no evidence of a diagnosis of osteoarthritis corroborated by objective findings or imaging studies. This particular medically was initially noted in the treatment plan on 03/18/2013. There has been no evidence of significant functional improvement or decrease in pain following the use of this medication. Furthermore, California Guidelines do not recommend muscle relaxants as a topical product. Again noted, any compounded product that contains at least 1 drug or drug class that is not

recommended is not recommended. **The request for Fluiflex (Flurbiprofen /Cyclobenzaprine 15/10%) cream 180gm is not medically necessary and appropriate.**

4) Regarding the request for TG Hot (Tramadol /Gabapentin /Menthol /Camphor /Capsaicin 8/10/2/.5%) cream 180gm:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics section, which is part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), pages 111-113, Topical Analgesics, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee has a date of injury of 2/23/2004. A review of the submitted records indicates the employee is currently being treated for persistent low back and hip pain. Objective findings on 6/14/2013 consisted of a scissor gait, spasm and tenderness of the paralumbar musculature, limited lumbar ranges of motion, and severely reduced left hip internal and external rotation with instability. The employee was diagnosed with cerebrovascular accident, significant spinal sprain/strain syndrome, lumbar discopathy, left-sided sciatica, left hip arthritis, right shoulder contusion, and possible rotator cuff injury. The medical records submitted provided for review indicate treatments have included medications. A request for TG hot (Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/.5%) cream 180gm was submitted.

Chronic Pain Medical Treatment Guidelines state topical analgesics are recommended as an option for treatment, but are largely experimental in use and primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the clinical information received for this review, there is no documented evidence of a diagnosis including neuropathic pain. There is also no evidence of a trial of antidepressants and anticonvulsants that have failed. California Guidelines further state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. NSAIDs are recommended for short-term duration of treatment for osteoarthritis. Recommended use includes 4 to 12 weeks. The only FDA-approved NSAID medication for topical use includes diclofenac which is indicated for relief of osteoarthritis pain in joints that lend themselves to a topical treatment, including ankle, elbow, foot, hand, knee, and wrist. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Indications include osteoarthritis, fibromyalgia, and chronic non-specific back pain. Gabapentin is not recommended for topical use and there is no evidence for the use of any other antiepilepsy drug as a topical product as well. There was also no evidence for use of any muscle relaxant as a topical product. As per the clinical notes submitted, the employee is well beyond the recommended use of a topical NSAID including 4 to 12 weeks duration. **The**

request for TG Hot (Tramadol /Gabapentin /Menthol /Camphor /Capsaicin 8/10/2/.5%) cream 180gm is not medically necessary and appropriate.

5) Regarding the request total hip replacement, 2 day inpatient stay, post op physical therapy left hip times 12 to start one month after surgery:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG).

The Expert Reviewer relied on the Official Disability Guidelines (ODG), Hip Chapter, Arthroplasty, which is a Medical Treatment Guideline (MTG) that is not part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee has a date of injury of 2/23/2004. A review of the submitted records indicates the employee is currently being treated for persistent low back and hip pain. Objective findings on 6/14/2013 consisted of a scissor gait, spasm and tenderness of the paralumbar musculature, limited lumbar ranges of motion, and severely reduced left hip internal and external rotation with instability. The employee was diagnosed with cerebrovascular accident, significant spinal sprain/strain syndrome, lumbar discopathy, left-sided sciatica, left hip arthritis, right shoulder contusion, and possible rotator cuff injury. The medical records submitted provided for review indicate treatments have included medications. A request for total hip replacement, 2 day inpatient stay, post op physical therapy left hip times 12 to start one month after surgery.

Official Disability Guidelines state hip arthroplasty is recommended when all reasonable conservative measures have been exhausted and other reasonable surgical options have been seriously considered or implemented. Guidelines further state criteria for hip joint replacement includes conservative care with medications or steroid injections, plus subjective clinical findings of limited range of motion, night time pain, or no pain relief following conservative care, plus objective clinical findings of age over 50 years and BMI of less than 35, plus imaging clinical findings of osteoarthritis on a standing x-ray or arthroscopy. Per medical records submitted and reviewed, there is no indication this employee has exhausted all reasonable conservative measures. There was no evidence of a failure at conservative treatment to include medication management, injection therapy, or exercise and physical methods. As per the medical records submitted, there is no evidence providing a body mass index of less than 35. Based on the clinical information received and Official Disability Guidelines, the request for a total hip replacement is not appropriate at this time. Given the non-certification of the total hip replacement, the request for 2 days inpatient stay with 12 sessions of postoperative physical therapy is not applicable at this time. **The request for total hip replacement, 2 day inpatient stay, post op physical therapy left hip times 12 to start one month after surgery is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/ldh

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.