

Case Number:	CM13-0002771		
Date Assigned:	09/19/2013	Date of Injury:	07/04/2012
Decision Date:	01/02/2014	UR Denial Date:	07/19/2013
Priority:	Standard	Application Received:	07/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 physician 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.

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 underlying date of injury in this case is 07/04/2012. This patient is a 34-year-old man. History and diagnoses include lumbar radiculopathy, chronic pain, and herniated nucleus pulposus at L4-L5 and L5-S1 with stenosis and bilateral foraminal narrowing. As of 06/19/2013, the patient reported low back pain and left lower extremity symptoms which were possibly a bit better. The patient reported some relief with acupuncture which allowed him to sleep better. He did complain of weakness and aching in the left lower extremity. The patient had decreased lumbar motion with intact sensation and with slight weakness in left hip flexion and knee extension and also weakness in left knee flexion or dorsiflexion. An initial physician reviewer recommended non-certification of ketoprofen cream, noting that this agent was not FDA approved due to adverse side effects and a base-dependent absorption rate that was modified pending additional information regarding functional benefit from this medication. Diclofenac was non-certified based on the lack of specific improvement regarding the decrease in pain levels or improvement in function. Cyclobenzaprine was non-certified given that the treatment guidelines did not support its continued use. Multiple physician notes including 06/12/2013 indicate the patient reported that his medications, including specifically tramadol ER and Voltaren ER, continued to decrease his pain and normalize his function.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen cream 20%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 112.

Decision rationale:

Tramadol ER 150mg, #9: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113.

Decision rationale: The Chronic Pain Guidelines indicate that tramadol is not recommended as a first-line oral analgesic. The medical records provided for review do not indicate additional information to clarify a rationale for using other than first-line treatment only specific functional benefit of this synthetic opioid to support its use. The request for Tramadol ER 150 mg #9, with no refills is not medically necessary and appropriate.

Diclofenac Sodium ER 100mg, #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The Chronic Pain Guidelines indicate that anti-inflammatories are the traditional first-line of treatment to reduce pain so activity and functional restoration can resume. While such specific criteria are included in the California Treatment Guidelines for medications with specific and potential for abhorrent behavior such as opioids, the guidelines do not contain such strict requirements for anti-inflammatory medications, which have very limited potential for abuse. The medical records provided for review indicate that the employee reported improved function and reduced pain. The documentation in the medical records is consistent with the guidelines. The request for Diclofenac Sodium ER 100 mg #60, with no refills is medically necessary and appropriate.

Cyclobenzaprine 7.5mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 64.

Decision rationale: The Chronic Pain Guidelines indicate that Cyclobenzaprine is recommended for a short course of therapy. The guidelines also indicate that the medical index table does not allow for a recommendation for chronic use. The medical records provided for review do not indicate an alternate rationale for this medication in a concurrent chronic setting. This medication does not support or meet the guidelines. The request for Cyclobenzaprine 7.5 mg #90, with no refills is not medically necessary and appropriate.