

Case Number:	CM13-0018874		
Date Assigned:	10/11/2013	Date of Injury:	06/05/2009
Decision Date:	01/15/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/30/2013

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 Internal Medicine and is licensed to practice in New York. 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant sustained a work related injury on 06/05/2009. The mechanism of injury was not provided. His diagnosis is chronic low back pain with radiculopathy. He has MRI demonstrated L4-L5 stenosis with a L4-L5 disc herniation. On 08/18/2011, he underwent lumbar disc replacement arthroplasty at L5-S1. Per the medical documentation he continues with low back pain with associated paravertebral muscle spasms and radiculopathy. There is decreased range of motion of the lumbar spine. Treatment has included medical therapy with Ultram, Motrin, and Lidoderm patch, and injection therapy with medial branch nerve block. The treating provider has requested continued treatment with Ultram, Motrin, and Lidoderm patch.

IMR ISSUES, DECISIONS AND RATIONALES

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

prescription for Ultram: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-96.

Decision rationale: Per California MTUS, Ultram (Tramadol) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The

treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical records, there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. In addition, the documentation provided is lacking of California MTUS Opioid compliance guidelines including risk assessment profile, attempts at weaning/tapering, updated urine drug screen, and an updated signed patient contract between the provider and the claimant. Medical necessity for continued Ultram therapy has not been established. The request for Ultram is not medically necessary and appropriate.

prescription for ibuprofen: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 70.

Decision rationale: The review of the medical documentation indicates the patient requires ibuprofen therapy for his chronic pain condition. NSAIDs such as ibuprofen are the traditional first line of treatment to reduce pain so activity and functional restoration can resume. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective non-steroidal anti-inflammatory drugs in chronic low back pain. Because the patient has chronic low back pain medical necessity is established for ibuprofen at this time. The request for ibuprofen is medically necessary and appropriate

prescription for Lidoderm: 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): 111-113.

Decision rationale: There is no documentation provided necessitating use of the requested topical medication, Lidoderm. Per California MTUS Guidelines, topical analgesics are 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. Lidoderm is recommended for the treatment of localized peripheral pain after there has been evidence of a trial of first-line therapy for neuropathic pain such as use of tricyclic antidepressants, SNRI antidepressants or gabapentin or Lyrica. It is not a

first line treatment. The medical documentation provided has not established medical necessity for Lidoderm therapy. The request for Lidoderm is not medically necessary and appropriate.