

Case Number:	CM13-0023746		
Date Assigned:	11/15/2013	Date of Injury:	01/24/1994
Decision Date:	01/24/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	09/13/2013

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Ohio and Texas. 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 patient is a 66-year-old male who reported an injury on January 24, 1994. The patient is currently diagnosed with cervical spondylosis, herniated nucleus pulposus with foraminal stenosis at C4-5, herniated nucleus pulposus at C6-7, bilateral upper extremity radiculopathy, bilateral L5 pars intra-articularis fracture with spondylolisthesis, large disc herniation at L4-5, large herniated nucleus pulposus with foraminal stenosis at L3-4, herniated nucleus pulposus with facet arthropathy at L2-3, bilateral lower extremity radiculopathy, status post right knee arthroscopy, status post left De Quervain's surgery, status post left foot tyelectomy with hallux rigidus, and weight gain secondary to industrial injuries. The patient was recently seen by [REDACTED] on September 24, 2013. The patient reported 5/10 low back pain with radiation to the right lower extremity. The patient also reported left wrist and right knee pain. Physical examination revealed paraspinal spasm and tenderness, positive Kemp's testing, 0 degree to 130 degree range of motion of the right knee with mild effusion, and restricted range of motion of the right wrist tenderness to palpation. Treatment recommendations included continuation of physical therapy exercises, and continuation of current medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

one (1) prescription of Flurbiprofen 20%, Ketoprofen 20%, Ketamine 10% gel (Express Scripts), between July 16, 2013 and November 5, 2013,: 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: The Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The only FDA approved topical NSAID includes diclofenac, which is indicated for the relief of osteoarthritis. As per the clinical notes submitted, there is no indication that this patient has failed to respond to first line oral medications prior to the initiation of a topical analgesic. As the Chronic Pain Medical Treatment Guidelines do not recommend flurbiprofen, ketoprofen, or topical Ketamine, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

one (1) Urine drug screening: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009), pg 33.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77 & 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The ODG state the frequency of urine drug testing should be based on documented evidence of risk stratification, including the use of a testing instrument. Patients at low risk of addiction or aberrant behaviors should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the clinical notes submitted, there is no evidence of noncompliance or misuse of medications. There is also no evidence that this patient falls under a high risk category that would require frequent monitoring. The medical necessity for ongoing testing cannot be determined as medically appropriate. Therefore, the request is non-certified.