

Case Number:	CM13-0036009		
Date Assigned:	12/13/2013	Date of Injury:	09/28/2000
Decision Date:	02/06/2014	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	10/18/2013

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 Cardiology, has a Fellowship trained in Cardiovascular Disease and is licensed to practice in 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 55-year-old male who reported an injury on 09/28/2000, and ultimately required lumbar fusion. However, the patient continued to have chronic low back pain that was managed with physical therapy, acupuncture, and medications. The patient's most recent clinical examination revealed the patient had regular low back complaints radiating into the right lower extremity rated as a 6/10, but is exacerbated by prolonged activities. Physical findings included decreased range of motion secondary to pain, decreased sensation in the right L3 through S1 dermatomes. The patient's diagnoses included L2-3 disc herniation, L3-4 retrolisthesis with a disc herniation, residual radiculopathy, status post L4-5 and L5-S1 fusion with instrumentation. The patient's treatment plan included epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen with Lidocaine Ultra cream 180gm with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (2009).

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

Decision rationale: The requested ketoprofen with lidocaine ultra cream 180 gm with 1 refill is not medically necessary or appropriate. The clinical documentation submitted for review did not provide any evidence of significant pain relief resulting from medication usage. California Medical Treatment Utilization Schedule does not recommend the use of ketoprofen as a topical agent as it is not FDA approved to be used in a topical formation. Additionally, the FDA has not approved topical lidocaine in any other formulation than a dermal patch. California Medical Treatment Utilization Schedule states that any topical formulation that contains at least 1 drug or drug class that is not supported by Guideline recommendations is not supported. As ketoprofen and lidocaine are not supported by California Medical Treatment Utilization Schedule as topical agents in cream form, the requested topical medication would not be indicated. As such, the requested Ketoprofen with lidocaine ultra cream 180 gm with 1 refill is not medically necessary or appropriate.

Ultram 50mg, #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Tramadol (Ultram®) Page(s): 60 and 113.

Decision rationale: The requested Ultram 50 mg, #60 with 1 refill is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. California Medical Treatment Utilization Schedule recommends that medications that are used in the management of chronic pain be supported by documentation of increased functional benefit and symptom response. The clinical documentation submitted for review does not provide any evidence that the patient has any increased functional capabilities or any symptom relief as a result of this medication. Therefore, continued use would not be supported. As such, the requested Ultram 50 mg, #60 with 1 refill is not medically necessary or appropriate.

Prilosec 20mg, #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (2009).

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

Decision rationale: The requested Prilosec 20 mg, #30, with 1 refill is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectants for patients who are at risk for gastrointestinal events related to medication usage. The clinical documentation submitted for review did not provide any evidence of an assessment of the patient's gastrointestinal system that would provide deficits that require medication management. Additionally, there is no assessment of the patient's risk of development of gastrointestinal events related to medication usage. Therefore, continued use of

this medication would not be indicated. As such, the requested Prilosec 20 mg, #30 with 1 refill is not medically necessary or appropriate.

One (1) functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), fitness for Duty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89.

Decision rationale: The requested Functional Capacity Evaluation is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends the use of a Functional Capacity Evaluation to obtain a more precise delineation of patient capabilities than is available from routine physical examination and notes. The clinical documentation submitted for review does not provide any evidence that the patient's treatment plan would benefit from an additional more intense evaluation than what is provided during a regular physical examination. Additionally, Official Disability Guidelines recommend the use of Functional Capacity Evaluations for patients who are at or close to maximum medical improvement when evaluation is being used to determine the patient's ability to perform job duties. The clinical documentation submitted for review does not provide any evidence that the patient is at or close to maximum medical improvement. Additionally, there is no documentation that the patient has failed to a return-to-work attempt or that there is an intention to return to work. As such, the requested Functional Capacity Evaluation is not medically necessary or appropriate.