

Case Number:	CM13-0039488		
Date Assigned:	12/18/2013	Date of Injury:	01/25/2005
Decision Date:	05/15/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/28/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 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 injured worker is a 65-year-old female who reported an injury on 01/25/2005. The mechanism of injury was not stated. Current diagnoses include cervical discopathy, bilateral carpal tunnel syndrome, left wrist strain, lumbar sprain, lumbar discopathy, hip contusion, leg contusion, and left knee contusion/strain. The injured worker was evaluated on 08/05/2013. The injured worker reported persistent lower back pain with bilateral lower extremity radiculopathy. Physical examination of the cervical spine revealed tenderness to palpation with negative Spurling's maneuver. Examination of the lumbar spine revealed tenderness to palpation with bilateral sciatic notch tenderness. Treatment recommendations at that time included physical therapy, a urine drug screen, and continuation of current medication, including naproxen, Cartivisc, Exoten-C pain relief lotion, Amitramadol-DM Ultracream, and Gabaketolido cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY (FREQUENCY/DURATION NOT SPECIFIED): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. There is no specific frequency, quantity, or body part listed in the current request. Therefore, the request is non-certified.

URINE SPECIMEN (OBTAINED 08/05/13): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 90-91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77, 89.

Decision rationale: California MTUS Guidelines state urine drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification, including the use of a testing instrument. As per the documentation submitted, the date of injury is greater than 8 years ago, and there is no indication of noncompliance or misuse of medication. There is also no indication that this injured worker falls under a high risk category that would require frequent monitoring. Therefore, the medical necessity for ongoing, repeat screening has not been established. As such, the request is non-certified.

PRESCRIPTION OF CARTIVISC 500/200/150MG, ONE (1) EVERY 8 HOURS #90:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GLUCOSAMINE (AND CHONDROITIN SULFATE), Page(s): 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

Decision rationale: California MTUS Guidelines state glucosamine and chondroitin sulfate is recommended as an option given the low risk in patients with moderate arthritis pain. There is no documentation of osteoarthritis pain. Additionally, the injured worker has utilized Cartivisc 500/200/150 mg since 05/2013. There is no documentation of objective functional improvement. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.

PRESCRIPTION OF EXOTEN-C PAIN RELIEF LOTION (MENTHYL SALICYLATE 20%/ MENTHOL 10%/ CAPSAISIN 0.005%) 113.4 GRAMS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Capsaicin is available in a 0.025%, 0.075%, and 0.0375% formulation. The current request for Exoten-C pain relief lotion with capsaicin 0.005% cannot be determined as medically appropriate. There is also no evidence of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There is also no frequency listed in the current request. Therefore, the request is non-certified.

PRESCRIPTION OF AMITRAMADOL- DM ULTRACREAM (AMITRIPTYLINE 4%/ TRAMADOL 20%/ DEXTROMETHORPHAN 10%) 120 GRAMS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS 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. There is no documentation of a failure to respond to oral antidepressants or anticonvulsants prior to the initiation of a topical analgesic. There is also no frequency listed in the current request. Therefore, the request is non-certified.

PRESCRIPTION OF GABAKETOLIDO (GABAPENTIN 6%/ KETOPROFEN 20%/ LIDOCAINE 6.15 %) 120 GRAMS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Gabapentin is not recommended, as there is no evidence for the use of any anti-epilepsy drug as a topical product. Therefore, the request cannot be determined as medically appropriate. There is also no frequency listed in the current request. As such, the request is non-certified.