

Case Number:	CM13-0060250		
Date Assigned:	12/30/2013	Date of Injury:	04/21/2006
Decision Date:	03/26/2014	UR Denial Date:	11/15/2013
Priority:	Standard	Application Received:	12/03/2013

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 multiple injuries on 04/21/2006. He was reportedly pulling a rack of bread down a ramp when the ramp gave way, causing him to fall backward. The rack of bread fell on top of him, striking him in the face, head, shoulder, chest, right hand and left knee. His diagnoses include chest wall contusion, cervical discopathy, left knee pain and lumbar discopathy. He has ongoing pain in the neck, lower back, and left knee. On exam he has reduced range of motion and muscle spasms in the cervical and lumbar spine, tenderness over the paralumbar muscles and the left knee medial joint line, and aggravation of the left knee complaints of pain with McMurray's test and valgus/varus stress testing. Treatment has included medical therapy, surgeries (left knee meniscectomy and ACL reconstruction, and removal of hardware in the left lower extremity), physical therapy, and biofeedback. The treating provider requested an X-force low back brace between 11/12/2013 and 1/11/2014, Tramadol Extended release 150mg # 30 between 11/12/2013 and 1/11/2014, Restone 3/100mg #30, and a compounded medication Gabaketolido cream 6/20/6.15% 240 grams between 11/12/2013 and 1/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

(1) X-force Low back Brace between 11/12/2013 and 1/11/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: The MTUS/ACOEM Guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The claimant has a history of chronic low back pain and has been treated with medical and interventional therapies. To date, he continues with low back pain with paralumbar muscle spasm. Medical necessity for the requested X-force back brace has not been established. The requested item is not medically necessary.

Tramadol extended release 150mg #30 between 11/12/2013 and 1/11/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Workers' Compensation, Online Edition, Chapter: Pain

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93, 94-96.

Decision rationale: The review of the medical documentation indicates that the requested medication, Ultram ER 100mg is indicated for the treatment of the claimant's chronic pain condition. The Chronic Pain Guidelines indicate that Ultram ER (Tramadol extended release) 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 documentation there has been no indication of the medication's pain relief effectiveness, or clear documentation that he has responded to ongoing opioid therapy. In addition, the results of a urine drug screen obtained on 07/26/2013 did not show evidence of Tramadol, which is a finding inconsistent with his prescribed medical regimen at the time. Based on the currently available information, the medical necessity of Ultram ER was not established for the period in question. The requested medication was not medically necessary.

Restone 3/100mg #30 between 11/12/2013 and 1/11/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/cdi/restone.html>

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine 2013- Medications for Sleep.

Decision rationale: [REDACTED] indicates that Restone is a medication which contains melatonin and tryptophan. The medication is used for sleep problems, jet lag, and anxiety or depression,

and boosting the immune system. There is no specific indication that the claimant has any sleep related issues. The medical necessity for the requested item has not been established. The requested item is not medically necessary.

One (1) jar of compounded Gabapentol Cream 6%/20%/6.15% 240 grams between 11/12/2013 and 1/11/2014: 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 compounded medication. The Chronic Pain Guidelines indicate that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including non-steroidal anti-inflammatory drugs (NSAIDs), opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, gamma agonists, prostanooids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). Any compounded product that contains at least one (1) drug (or drug class) that is not recommended is not recommended. In this case, topical Gabapentin and Ketoprofen are not indicated for the treatment of chronic pain. Medical necessity for the requested item has not been established. The requested item is not medically necessary.