MAXIMUS Federal Services

Case Number:	CM14-0005763		
Date Assigned:	02/07/2014	Date of Injury:	07/08/2011
Decision Date:	07/17/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/15/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 patient is a 42-year-old male with a 7/8/11 date of injury with ongoing low back pain, reduced range of motion, and positive SLR. Mechanism of injury was when he was using a pitchfork to remove the weeds, and as he twisted to throw them into a truck, heard a pop in his low back and experienced pain, with pain radiating to his right lower extremity starting later that night. AME in 2012 recommended additional conservative treatment, as well as possibly a one level micro-discectomy. On 5/18/13 the orthopedic spine surgical consultation documented mid and low back pain. It was noted that the patient denied taking medications on the date of examination. Clinically, there was tenderness in the low back, muscle spam, and reduced range of motion. Sensation and DTRs were intact. SLR was positive bilaterally. Radiographs were taken and revealed 3 mm L3-4 herniated nucleus pulposus. Pool therapy and LINT therapy was requested. Topical medications were prescribed, which allow reduction in total amount of oral medication. Creams also allow an alternative when oral medications are not well tolerated. On 11/15/12 progress note described ongoing and persistent low back pain with lumbar tenderness, still lumbar range of motion, and positive SLR. Treatment to date has included PT, activity modification, and medication. The patient refused ESI.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMITRIPTYLINE 4%, DEXTROMETORPHAN 10%, TRAMADOL 20%, ULTRADERM 30G X 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Page(s) 111-113.

Decision rationale: Medical necessity for the requested topical agent is not establisehd. The patient has a 2011 of injury. This reqeust obtaiend an adverse determiation in early 2014 based on progress notes from 2012. CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, Baclofen and other muscle relaxants, and gabapentin and other anti-epilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Within the context of this appeal, additional medical records were provided. 5/18/13 orthopedic spine surgical consultation documented reduction in PO medication use, and intolerability to some PO medications. However, as further referenced guidelines, there is little justification for topical applications of antidepressants or opiates. Therefore the request is not medically necessary.

DICLOFENAC 10%, FLURBIPROFEN 25%, ULTRADERM 30G X 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Page(s) 111-113.

Decision rationale: Medical necessity for the requested topical agent is not establisehd. The patient has a 2011 of injury. This reqeust obtaiend an adverse determiation in early 2014 based on progress notes from 2012. CA MTUS Chronic Pain Medical Treatment Guidelines state that NSAIDs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Within the context of this appeal, additional medical records were provided. 5/18/13 orthopedic spine surgical consultation documented reduction in PO medication use, and intolerability to some PO medications. However, it has not been noted why the patient requires a topical medication with agents that are not guideline supported, instead of agents that are recommended for topical formulation. Guidelines do not support topical NSAIDs. Therefore the request is not medically necessary.