

Case Number:	CM14-0007358		
Date Assigned:	02/10/2014	Date of Injury:	01/19/2009
Decision Date:	06/09/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/21/2014

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 Orthopedic Surgery 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 52 year old male who sustained an injury on 01/19/09. No specific mechanism of injury was noted. This appeared to be due to cumulative trauma. The patient has been followed for complaints of chronic low back pain radiating to the lower extremities. No prior surgical history was noted. The patient's physical examination on 10/25/13 noted tenderness and spasms in the lumbar musculature. At that time, the patient was recommended to attend aquatic therapy and was prescribed a topical lotion as well as Hydrocodone. The clinical report on 12/30/13 indicated the patient continued to have severe low back pain radiating to the lower extremities, left side worse than right. On physical examination, there were noted spasms and tenderness to palpation with positive straight leg raise findings to the left. There was decreased sensation in a left L5-S1 distribution. The patient was recommended to continue with Hydrocodone at this visit. The patient was noted to have some gastrointestinal upset with the use of Hydrocodone which required the use of Omeprazole. The patient was also recommended to utilize a topical compounded medication that contained Flurbiprofen, Cyclobenzaprine, and a separate compounded medication that included Tramadol and Gabapentin. Although there are forms indicating samples for drug screen testing taken, no actual toxicology reports were available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

OMEPRAZOLE 20MG #60: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitor Section.

Decision rationale: In regards to the use of Omeprazole 20mg, quantity 60, this reviewer would have recommended this medication as medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. The patient was being actively prescribed narcotics as of December of 2013 and was noted to have had gastrointestinal side effects with this medication. Given the side effects from the use of Norco, guidelines would have recommended the use of Omeprazole to address gastrointestinal upset. Therefore, this reviewer would have recommended this medication as medically necessary.

HYDROCODONE/APAP 10/325MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Section Page(s): 88-89.

Decision rationale: In regards to Hydrocodone 10/325mg, quantity 60, this reviewer would not have recommended this medication as medically necessary. There is insufficient indications in the clinical notes that the patient was receiving any substantial functional improvement or other benefits from the continuing use of Hydrocodone to warrant its ongoing use. There was no clear reduction in pain scores. Also, there was no documentation regarding compliance testing. Although it appears that multiple samples were taken for drug screen analysis, no finalized confirmatory report showing consistent use of Hydrocodone was available for review. As such, this reviewer would not have recommended this medication as medically necessary.

FLURIFLEX CREAM #180: Upheld

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

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

Decision rationale: In regards to the compounded topical medication Fluriflex which contained both Flurbiprofen and Cyclobenzaprine, this reviewer would not have recommended this compounded topical medication as medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of

compounded topical medication be approved for transdermal use. This compound contains flurbiprofen and cyclobenzaprine which are not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound cannot be supported as medically necessary.

TGICE CREAM #180: 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: Gabapentin, this reviewer would not have recommended this compounded topical medication as medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Tramadol and Gabapentin which are not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound cannot be supported as medically necessary.