

Case Number:	CM14-0009295		
Date Assigned:	02/14/2014	Date of Injury:	05/02/2010
Decision Date:	06/24/2014	UR Denial Date:	01/09/2014
Priority:	Standard	Application Received:	01/23/2014

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, 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 injured worker is a 42-year-old female who reported an injury on 05/02/2010 due to an unknown mechanism. The clinical note dated 01/14/2014 indicated diagnoses of lumbar radiculopathy with herniated discs, lumbar myofascial pain, and lumbar facet arthropathy. On physical examination of the lumbar spine, there was tenderness upon palpation in the lumbosacral musculature and over the lumbar spinous processes. Range of motion revealed complaints of end range pain with flexion. The lumbar facet compression test caused the injured worker to have pain in the low back which radiated into the buttocks and into her thighs. Lasegue's neural tension test was positive. The injured worker reported pain which radiated down the legs, left worse than right. On 10/16/2013, the injured worker had an MRI of the lower back. The MRI revealed L4-5 circumferential disc bulge. There was also moderate bilateral facet joint arthropathy. These findings resulted in minimal right neural foraminal narrowing. There was a 5 mm broad-based posterior disc protrusion which became slightly more prominent in the right paracentral zone. MRI scan of the left hip revealed mild narrowing of the femoroacetabular joints bilaterally. The injured worker's medication regiment included Hydrocodone, Acetaminophen, Trazodone, Sulfameth/Trimethoprim, Metronidazole, Ibuprofen, and Norco. The Request for Authorization was submitted on 12/18/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

PENNSAID 1.5MG #120 WITH 3 REFILLS: Upheld

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

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

Decision rationale: The request for Pennsaid 1.5mg #120 with 3 refills is non-certified. The California MTUS Guidelines do not recommend topical Pennsaid as a first-line treatment. Topical Diclofenac, the equivalent of Pennsaid, is recommended for osteoarthritis after failure of an oral NSAID or contraindications to oral NSAIDs, and after considering the increased risk profile with diclofenac, including topical formulations for the treatment of the signs and symptoms of osteoarthritis of the knee, elbow or other joints. Diclofenac would be recommended for treatment of osteoarthritis and tendinitis of the knee, elbow, or other joints that are amenable to topical treatment. The included medical documents lack evidence of the injured worker having any contraindications to oral pain medications, and also lacks evidence that these medications failed to meet the provider's expectations of pain relief. The included medical documents does not suggest objective symptoms of osteoarthritis and/or tendinitis of the knee, elbow or other joints for the injured worker. Therefore, per the CA MTUS guidelines, the request for Pennsaid 1.5 mg #120 with 3 refills is not medically necessary.

FLECTOR PATCH 1.3MG #30 WITH 3 REFILLS: Upheld

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

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

Decision rationale: The request for Flector patch 1.3mg #30 with 3 refills is non-certified. The California MTUS guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The included medical documents lack evidence of the injured worker having any contraindications to oral pain medications, and also lacks evidence that these medications failed to meet the provider's expectations of pain relief. The guidelines do not approve Diclofenac as a patch, therefore, per the California MTUS guidelines, the request for Flector patch 1.3mg #30 with 3 refills is not medically necessary.