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| Case Number: | CM14-0102643 | | |
| Date Assigned: | 07/30/2014 | Date of Injury: | 02/03/2013 |
| Decision Date: | 09/10/2014 | UR Denial Date: | 06/11/2014 |
| Priority: | Standard | Application Received: | 07/02/2014 |

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 Nevada. 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 records presented for review indicate that this 44 year-old individual was reportedly injured on 2/3/2013. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated 4/16/2014, indicates that there are ongoing complaints of groin pain. The physical examination demonstrated: positive swelling in the right inguinal region. Tenderness to palpation. Tenderness in the scrotal area. Testicles are descended, positive tenderness to palpation in this area. Tender in the right inguinal area. Obvious surgical scarring in the area. Diagnostic imaging studies include a CT scan of the abdomen and pelvis on 4/10/2014 which states partial sigmoid colectomy with intact colonic and suture within the pelvis. Previous treatment includes conservative treatment only. A request had been made for Flector patch #90, Norco 10/325 mg #90, Flurbiprofen 20%, Tramadol 20% in Mediderm base, Gabapentin 10%, Amitriptyline 10%, Dexamethorphan 10%, was not certified in the pre-authorization process on 6/11/214.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flector patch 1.3% #90: 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 in Worker's Compensation, Online Edition, Chapter: Pain; Flector patch (diclofenac epolamine).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009); Page(s): 111-113 of 127.

Decision rationale: MTUS guidelines support topical NSAIDs for the short-term treatment of osteoarthritis and tendinitis for individuals unable to tolerate oral non-steroidal anti-inflammatories. The guidelines support 4-12 weeks of topical treatment for joints that are amendable to topical treatments; however, there is little evidence to support treatment of osteoarthritis of the spine, hips or shoulders. When noting the claimant's diagnosis, date of injury and clinical presentation, this request is not considered medically necessary.

Flurbiprofen 20%, Tramadol 20% in Mediderm #210g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009); Page(s): 111-113 of 127.

Decision rationale: MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class) that is not recommended, is not recommended". Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As such, this request is not considered medically necessary.

Gabapentin 10%, Amitriptyline 10%, Dexamethorphan 10% in Mediderm #210g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009); Page(s): 111-113 of 127.

Decision rationale: MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class) that is not recommended, is not recommended". Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As such, this request is not considered medically necessary.

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Hydrocodone/Acetaminophen, Criteria for use of opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 74-78, 88, 91 of 127.

Decision rationale: As noted in the MTUS this is for the short-term management of moderate to severe breakthrough pain. Furthermore, as outlined in the MTUS the treatment plan parameters outlined in the MTUS for chronic opioid use require noting if the diagnosis has changed, other medications being employed, if any attempt has been made to establish the efficacy of the medications and documentation of functional improvement. Furthermore, adverse effects have to be addressed. None of these parameters to continue this medication chronically have been measured. Therefore, the request is not medically necessary.