

Case Number:	CM14-0104770		
Date Assigned:	07/30/2014	Date of Injury:	07/18/2012
Decision Date:	09/26/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/07/2014

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 patient is a 37-year-old male with a date of injury of 07/18/2012. The listed diagnoses per [REDACTED] are: 1. Lumbar spondylolisthesis. 2. Posterolateral disk protrusion at L4-L5. 3. Status post hemilaminectomies at L4-L5 and L5-S1, 2011. According to progress report on 02/03/2014, the patient presents with persistent low back pain rated as 9/10 at its worst. Patient states the pain is accompanied with numbness and tingling. He is taking Anexsia for his pain which helps the pain come down from a 9/10 to a 3/10. Examination revealed decreased range of motion and tenderness to the paraspinal equally. Straight leg raise is positive at 60 degrees on the right. The patient also has difficulties with sleep, depression, and stress. The treater is requesting a psychiatric followup and evaluation, Keratek gel 4 ounce and compound medication that includes include Flurbiprofen 100 mg, Tramadol 100 mg, and ranitidine 100 mg. Utilization review denied the request on 06/20/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychiatric Follow-up and Evaluation: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 92, 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter:7, page 127.

Decision rationale: This patient presents chronic low back pain, difficulties with sleep, depression, and stress. The treater is requesting a psychiatric followup and evaluation. ACOEM Practice Guidelines second edition (2004) page 127 has the following: "The occupational health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." In this case, the treater is concerned for patient's continued depression. A psychiatric followup and evaluation may be indicated. The recommendation is for approval.

Kera-Tek Gel 4oz.: Upheld

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

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

Decision rationale: This patient presents chronic low back pain, difficulties with sleep, depression, and stress. The treater is requesting Kera-tek gel 4oz. Kera-tek gel contains methyl salicylate 28g and menthol 16g. The MTUS Guidelines allows for the use of topical NSAID for peripheral joint arthritis and tendonitis. This patient does not meet the indications for this topical cream. Recommendation is for denial.

Flurbiprofen/Tramadol/Ranitidine (100mg/100mg/100mg), #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-Compound Drug Uses.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78.

Decision rationale: This patient presents chronic low back pain, difficulties with sleep, depression, and stress. The treater is requesting "a 3-in-1 medication which includes Flurbiprofen 100 mg, tramadol 100 mg, and ranitidine 100 mg to continue to wean down from Anexsia." Utilization review denied the request stating the patient is not noted to be intolerant to first-line trials of standard oral flurbiprofen, tramadol, or ranitidine to warrant a compounded cream. The MTUS guidelines pg 76-78, criteria for initiating opioids recommends that reasonable alternatives have been tried, consider patient's likelihood of improvement, likelihood of abuse, etc. MTUS goes on to state that baseline pain and functional assessments should be made. Once the criteria have been met a new course of opioids may be tried at that time. The treater does not provide baseline pain or any functional assessments to necessitate a start of a new opioid. Recommendation is for denial.