MAXIMUS Federal Services

Case Number:	CM14-0106869		
Date Assigned:	07/30/2014	Date of Injury:	04/24/2013
Decision Date:	09/15/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	07/10/2014

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 & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 63-year-old male who reported an injury on 04/24/2013. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to his neck and low back. On the injured worker's treatment, history included physical therapy, chiropractic care, acupuncture, and multiple medications. The injured worker was evaluated on 05/12/2014. It was noted that the injured worker had persistent pain complaints of the neck and low back rated at 7/10. Objective findings included a mildly antalgic gait with restricted range of motion of the lumbar spine and decreased deep tendon reflexes of the plantarflexors, deltoids, biceps, and internal and external rotators. The injured worker's diagnoses included lumbar spine herniated disc, cervical spine herniated disc, degenerative disc disease of the thoracic spine, gait grade 1 anterolisthesis at the L4-5 and facet arthropathy of the cerival, thoracic, and lumbar spines. The injured worker's treatment plan included continuation of a home exercise program and medications. The injured worker's medications included LidoPro ointment, Trazodone, Orphenedrine, and Ketoprofen. A request for authorization form for a refill of medications to include LidoPro, Orphenadrine, Ketoprofen, and Trazodone was submitted on 05/12/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidopro topical ointment 4oz #1: Upheld

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

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

Decision rationale: The requested LidoPro topical ointment 4 oz, #1, is not medically necessary or appropriate. The clinical documentation submitted for review indicates that the injured worker has been on this medication since at least 12/2013. This compounded medication contains Menthol, Methyl Salicylate, Capsaicin, and Lidocaine. The California Medical Treatment Utilization Schedule does not recommend the use of Lidocaine in a cream or gel formulation, as it is not FDA-approved in this formulation for treatment of neuropathic pain. Additionally, the California Medical Treatment Utilization Schedule does not recommend the use of Capsaicin as a topical agent unless the injured worker has failed to respond to first-line chronic pain management treatments. The clinical documentation does not provide any evidence that the injured worker has failed to respond to anticonvulsants or antidepressants. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested LidoPro topical ointment 4 oz., #1, is not medically necessary or appropriate.

Trazodone 50mg tab #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: The requested Trazodone 50 mg tablets, #60, are not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 12/2013. The California Medical Treatment Utilization Schedule does not recommend the long- term use of benzodiazepines due to a high risk of physiological and psychological dependence. Therefore, continued use of this medication would not be supported in this clinical situation. Additionally, the request as it is submitted does not clearly define a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Trazodone 50 mg tablets, #60, is not medically necessary or appropriate.

Orphenadrine Citrate 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Pain Procedure Summary last Updated 05/15/2014, Non sedating Muscle Relaxants and Antispasticity/Aantispasmodics Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

Decision rationale: The requested Orphenadrine citrate 100 mg, #60, is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend muscle relaxants be used in the management of chronic pain. The clinical documentation indicates that the injured worker has been on this medication since at least 12/2013. The California Medical Treatment Utilization Schedule supports the use of muscle relaxants for short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation supports that the injured worker has been on this medication for duration to exceed guideline recommendations. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Orphenadrine citrate 100 mg, #60, is not medically necessary or appropriate.

Ketoprofen 75mg cap #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non Steroidal Anti Inflammatory Drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The requested Ketoprofen 75 mg capsules, #90, are not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 12/2013. The California Medical Treatment Utilization Schedule recommends nonsteroidal anti- inflammatory drugs as first-line medications in the management of chronic pain. However, the California Medical Treatment Utilization Schedule recommends that any medication used in the management of chronic pain be supported by documented functional benefit and pain relief. The clinical documentation submitted for review does not clearly identify a quantitative assessment of pain relief to support the continued use of this medication. Furthermore, there is no documentation of significant functional benefit to support continued use. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ketoprofen 75 mg capsules, #90, is not medically necessary or appropriate.