

Case Number:	CM14-0109139		
Date Assigned:	08/01/2014	Date of Injury:	05/07/2005
Decision Date:	09/09/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/14/2014

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 Anesthesiology, has a subspecialty in Internal Medicine and is licensed to practice in Pain Medicine. 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 55 year old male who suffered a work related injury on 05/07/05. The mechanism of injury was not documented. The most recent medical record submitted for review is dated 06/12/14. The injured worker presents with continued moderate low back pain. He has some weakness in his left leg with numbness. He is not actively participating in therapy. He takes Naprosyn 500mg as needed, tramadol 150mg as needed, Prilosec 20mg as needed, and gabapentin 300 mg as needed. He uses a topical cream of Ketoprofen, Gabapentin and Tramadol. On physical examination he walks with a slight imbalance due to weakness and numbness in his left leg. Motor and sensory functions are decreased in the left lower extremity at L4-S1. Flexion is 70 degrees. Straight leg raising in the sitting position on the left is at 80 degrees and in the lying position at 50 degrees. Diagnoses are status post lumbar decompression and fusion L4-5 and L5-S1, residual left lower extremity numbness, weakness and pain around the knee area, anterior and posterior approach for lumbar fusion, anxiety, insomnia, residual lumbar stenosis at L3-4, L4-5 and L5-S1, residual bilateral foraminal stenosis at L4-5 and L5-S1. Prior utilization review dated 06/27/14 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-Force With Solar Care: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, page(s) 116 Page(s): 116.

Decision rationale: Transcutaneous Electrical Nerve Stimulation (TENS) use is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. Criteria for TENS use includes documentation of pain of at least three months duration; evidence that other appropriate pain modalities have been tried and failed; a one-month trial period of the TENS unit should be documented with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial; other ongoing pain treatment should also be documented during the trial period including medication usage; and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. As such, the request for X-Force with Solar Care is not medically necessary.

Naprosyn 550 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, NSAIDs, specific drug list & adverse effects, page(s) 70 Page(s): 70.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs) are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). In this case, there is no documentation that these monitoring recommendations have been performed and the injured worker is being monitored on a routine basis. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. As such, the request for Naprosyn 550 mg #60 is not medically necessary.

Prilosec 20mg #90: Upheld

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 Inhibitors.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines Proton pump inhibitors (PPI) are indicated for patients at intermediate and high risk for gastrointestinal

events with concurrent use of non-steroidal anti-inflammatory drug (NSAID) use. Risk factors for gastrointestinal events include age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of aspirin (ASA), corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). In this case, there is no indication that the injured worker is at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. As such, the request for Prilosec 20mg #90 is not medically necessary.

Topical Compound-Ketoprofen, Gabapentin, Tramadol 150 g #30: 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 Page(s): 111.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, there is no indication in the documentation that these types of medications have been trialed and/or failed. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains ketoprofen, gabapentin, and tramadol which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, Ketoprofen, Gabapentin, Tramadol 150 g #30 is not medically necessary.