

Case Number:	CM14-0013069		
Date Assigned:	02/24/2014	Date of Injury:	10/28/2005
Decision Date:	06/26/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/31/2014

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 Orthopedic Surgery and is licensed to practice in Maryland. 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 43 year old male injured on 10/28/05 due to an undisclosed mechanism of injury. Current diagnoses include a medial meniscus tear, shoulder joint derangement, and lumbosacral neuritis. The documentation indicates the injured worker is status post fusion at L5-S1 on 02/04/10 with reported ongoing low back pain rated at 8/10 with associated radiation to the bilateral lower extremities and numbness and tingling. The documentation indicates tenderness over the pedicle screws at L5-S1 bilaterally, limited range of motion, positive straight leg raise bilaterally, weakness in the lower extremities 4/5, diminished Achilles reflex, and tenderness over the L5-S1 musculature. The documentation indicates the injured worker complained of stress, anxiety, depression, frequent nightmares, sleep difficulties, frequent constipation, bloating, stomach discomfort, heartburn, pain in the shoulders with popping/clicking/grinding sensation, numbness and tingling in the upper extremities, wrist and hand pain, cramping, and weakness. Current medications included Gabapentin, Amitiza, Omeprazol, Carisoprodol, Clonazepam, Citalopram, Trazadone, Docusate, Norco, and Nucynta. The clinical note dated 01/22/14 indicated the injured worker reported constant low back pain rated 7/10 radiating to the bilateral lower extremities with intermittent bilateral knee pain rated at 5/10 with associated giving way and locking. The injured worker rated his bilateral shoulder pain at 6/10 with radiation to the neck with associated numbness of the bilateral hands. The injured worker received trigger point injections in the office for continued pain. The initial request for Hydrocodone/Acetaminophen 10/325mg #90, Omeprazole 20mg #60, Ketoprofen powder 20% 30 grams cream, Cyclobenzaprine powder 10% 30 grams cream, Gabapentin powder 10% 30 grams cream was initially non-certified on 12/27/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE APAP 10/325 MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Hydrocodone APAP 10/325 MG #90 cannot be established at this time. Therefore, the request is not medically necessary.

OMEPRAZOLE 20 MG #60: 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: As noted in the Official Disability Guidelines - Online version, Pain Chapter, proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. Risk factors for gastrointestinal events include age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The documentation indicates the patient reports symptoms associated with gastrointestinal irritation. As such, the request for Omeprazole 20 MG #60 cannot be established as medically necessary. Therefore, the request is not medically necessary.

KETOPROFEN POWDER 20% 30 G CREAM: 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.

Decision rationale: As noted on page 111 of the 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. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Ketoprofen has 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, based on guidelines and a review of the evidence, the request for Ketoprofen Powder 20% 30 G Cream is not medically necessary.

CYCLOBENZAPRINE POWDER 10% 30 G CREAM: 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.

Decision rationale: As noted on page 111 of the 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. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Cyclobenzaprine has 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, based on guidelines and a review of the evidence, the request for Cyclobenzaprine Powder 10% 30 G Cream is not medically necessary.

GABAPENTIN POWDER 10% 30 G CREAM: 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.

Decision rationale: As noted on page 111 of the 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. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug

Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Gabapentin has 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, based on guidelines and a review of the evidence, the request Gabapentin Powder 10% 30 G Cream is not medically necessary.