

Case Number:	CM14-0019966		
Date Assigned:	04/28/2014	Date of Injury:	07/13/2012
Decision Date:	07/18/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/18/2014

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 Anesthesiologist Pain Medicine, and is licensed to practice in Florida. 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 53-year-old male who reported an injury on 07/13/2012 after lifting pallets that reportedly injured his low back. The injured worker was evaluated on 03/11/2014. It was documented that the injured worker had 10/10 low back pain radiating into the bilateral lower extremities. The injured worker's medications included Tylenol #3, omeprazole 20 mg, Flexeril 10 mg, and topical creams. It was noted within the documentation that the injured worker was being monitored for aberrant drug behavior with urine drug screens. Physical findings included limited range of motion secondary to pain with a positive straight leg raising test and weakness in the bilateral lower extremities. The injured worker had sensory deficits in the bilateral L4-5 and S1 dermatomal distributions. The injured worker's diagnoses included critical stenosis at L1-2 and L5-S1, left shoulder internal derangement with rotator cuff tear and labral tears, lumbar spine myofascial pain syndrome, gait derangement, and bilateral lower extremity radiculopathy. The injured worker's treatment plan included an MRI and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE NORCO 10/325MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, PAGE NARCOTICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The requested RETROSPECTIVE PURCHASE OF NORCO 10/325 MG #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, evidence of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation does indicate that the injured worker has a history of urine drug screens that are consistent with the prescribed medication schedule. However, the request as it is submitted states that it is a retrospective request. However, the date was not provided. In the absence of this information, there is no way to determine whether ongoing use of the requested medication is medically indicated in this clinical situation. As there is no way to determine the date of service in question, the requested RETROSPECTIVE PURCHASE OF NORCO 10/325 MG #30 is not medically necessary or appropriate.

RETROSPECTIVE ULTRACET 37.5/325MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ON-GOING MANGEMENT Page(s): 78.

Decision rationale: The requested RETROSPECTIVE ULTRACET 37.5/325 MG #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, evidence of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation does indicate that the injured worker has a history of urine drug screens that are consistent with the prescribed medication schedule. However, the request as it is submitted states that it is a retrospective request. However, the date was not provided. In the absence of this information, there is no way to determine whether ongoing use of the requested medication is medically indicated in this clinical situation. As there is no way to determine the date of service in question, the requested RETROSPECTIVE ULTRACET 37.5/325 MG #30 is not medically necessary or appropriate.

RETROSPECTIVE COMPOUNDED MEDICATION (FLURBIPROFEN 20%, KETOPROFEN 20%, KETAMINE 10%, GABAPENTIN 10%, CYCLOBENZAPRINE 10%, CAPSAICIN 0.0375%) FOR LUMBAR SPINE: 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 ANALGESICS Page(s): 111.

Decision rationale: The requested RETROSPECTIVE COMPOUNDED MEDICATION (FLURBIPROFEN 20%, KETOPROFEN 20%, KETAMINE 10%, GABAPENTIN 10%, CYCLOBENZAPRINE 10%, CAPSAICIN 0.0375%) FOR LUMBAR SPINE is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule (MTUS) does not recommend the use of nonsteroidal anti-inflammatory drugs for spine generated pain. The California Medical Treatment Utilization Schedule does not recommend ketoprofen in a topical formulation as it is not FDA approved as a topical analgesic. The CA MTUS does not recommend the use of gabapentin or cyclobenzaprine as a topical analgesic as there is little scientific evidence to support the efficacy and safety of this medication. The CA MTUS does not recommend the use of capsaicin or ketamine as first line medications. The use of these medications is limited to patients who have failed all other chronic pain management treatments. The clinical documentation fails to provide any evidence that the patient has not responded to first line treatments to include anticonvulsants or antidepressants. The CA MTUS states that any medication that includes 1 drug or drug class that is not supported is not recommended. Additionally, the request as it is submitted is a retrospective request. However, no date of service was provided. In the absence of this information, there is no way to determine the appropriate documentation to support medical necessity. As such, the requested RETROSPECTIVE COMPOUNDED MEDICATION (FLURBIPROFEN 20%, KETOPROFEN 20%, KETAMINE 10%, GABAPENTIN 10%, CYCLOBENZAPRINE 10%, CAPSAICIN 0.0375%) FOR LUMBAR SPINE is not medically necessary or appropriate.