MAXIMUS Federal Services

Case Number:	CM14-0126215		
Date Assigned:	08/13/2014	Date of Injury:	12/13/2006
Decision Date:	09/22/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/08/2014

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 Pain Medicine and is licensed to practice in Texas. 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 61 year old male who had a work related injury on 12/13/06, the mechanism of injury is not described. The most recent clinical note submitted for review is dated 07/01/14. The injured worker is being seen for orthopedic reevaluation. The injured worker continues to complain of pain, weakness and hypersensitivity in the left upper extremity and in his right thigh. The injured worker notes some functional improvement and pain relief with the adjunct of the medication. The injured worker indicates he feels his left upper extremity and left leg are becoming weaker with time. Physical examination left upper extremity there are multiple well-healed surgical incisions in the forearm, with skin atrophy. The injured worker can fully supinate and pronate. There is hypersensitivity of the forearm. Left lower extremity there is a well-healed scar over the iliac crest, with tenderness. There is slight weakness with knee extension. Diagnoses crush injury, left forearm, with recurrent weakness, reconstruction, skin grafting. History of bone graft, left forearm. History of pulmonary embolism. History of left femoral nerve palsy with secondary hematoma.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the left upper extremity and left lower extremity 2x2 qty: 4:
Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. The documentation indicates the injured worker continues to have ongoing pain with prior benefit following physical therapy. As such, the request for Physical Therapy for the left upper extremity and left lower extremity 2x2 qty: 4 is recommended as medically necessary to allow for return, as well as knowledge and comfort with home exercise program and rehabilitation.

Ultram 50mg Qty: 60 refills 2: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids 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. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. 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 Ultram 50mg Qty: 60 refills 2 cannot be established at this time.

Lyrica 75mg Qty: 60 refills 2: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica) Page(s): 99.

Decision rationale: As noted on page 99 of the Chronic Pain Medical Treatment Guidelines, Pregabalin (Lyrica) has been documented to be effective in treatment of diabetic neuropathy, postherpetic neuralgia, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia. The clinical documentation establishes the presence of objective

findings consistent with neuropathy. As such, the request for this medication is recommended as medically necessary at this time.

DFGL (diclofenac 10% Flurbiprofen 10% Gabapentin 10% Topical lido-cane 5%) 120 grams Refills 2: 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 based on Non-MTUS Citation Food and Drug Administration (FDA).

Decision rationale: 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, 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: Gabapentin which 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 this compound cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.