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| Case Number: | CM14-0022968 | | |
| Date Assigned: | 02/26/2014 | Date of Injury: | 07/29/2009 |
| Decision Date: | 08/07/2014 | UR Denial Date: | 01/24/2014 |
| Priority: | Standard | Application Received: | 02/24/2014 |

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, 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 35-year-old male who reported an injury on 07/29/2009, due to an unknown mechanism of injury. The injured worker complained of pain to his lower back and left lower extremity rated 8/10. He also complains of right leg pain. On 04/15/2014, the physical examination revealed an abnormal toe and heel walk on the left, due to pain. He had tenderness in the paraspinous musculature of the lumbar region on the left, and midline tenderness was noted in the lumbar spine. There was decreased range of motion due to increased pain, with flexion at 15 degrees, extension at 3 degrees, rotation right and left at 20 degrees, and tilt right and left at 10 degrees. His sensory testing was normal with the pinwheel except for decreased pin sensation in the foot dorsum and posterolateral calf on the left. His motor examination by manual muscle testing was normal except for grade 4 plantar flexor, and toe extensor on the left. On examination of the lumbar spine, there was left sacroiliac tenderness noted on compression and sciatic nerve compression, was positive on the left. There were no diagnostic studies submitted for review. The injured worker had diagnosis of 2-level, L4-5 and L5-S1, disc herniation. There was no documentation of past treatment methods. A list of the injured worker's current medications was not submitted for review. The current treatment plan is for prescription of TGICE Cream 180 gm (as prescribed on 12/31/2013), and prescription of hydrocodone/APAP 10/325 mg #60 (as prescribed on 12/31/2013). The rationale was not submitted for review. The Request for Authorization Form for hydrocodone was dated 12/31/2013. The Request for Authorization Forms for TGICE Cream were dated 12/31/2013 and 04/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF TGICE CREAM 180GM (AS PRESCRIBED ON 12/31/13): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL NSAIDS, TOPICAL ANALGESICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for prescription of TGICE Cream 180 gm (as prescribed on 12/31/2013) is non-medically necessary. The injured worker had a history of low back pain and lower extremity pain. The CA MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The documentation failed to provide details regarding the specific agents included in the requested compound, as well as the expected benefit from each agent. There is no rationale why the injured worker would require a topical cream versus oral medications. In addition, the frequency for the proposed medication was not provided. Given the above, the request for prescription of TGICE Cream 180 gm (as prescribed on 12/31/2013) is not medically necessary.

PRESCRIPTION OF HYDROCODONE/APAP 10/325MG, #60 (AS PRESCRIBED ON 12/31/13): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-78.

Decision rationale: The prescription of hydrocodone/APAP 10/325 mg, #60 (as prescribed on 12/31/2013) is not medically necessary. The injured worker has a history of low back pain and lower extremity pain. The CA MTUS guidelines state in regards to opioids, that there must be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. It is recommended for ongoing monitoring that the 4 A's (analgesia, activities of daily living, adverse side effect, and aberrant drug taking behaviors) be present in documentation. There was a lack of documentation of a pain assessment to include current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Also, there was no documentation of the 4 A's required for ongoing monitoring of opioids. In addition, the frequency was not included with the request. Given the above, the request for prescription of hydrocodone/APAP 10/325 mg, #60 (as prescribed on 12/31/2013) is not medically necessary.

