

Case Number:	CM14-0026225		
Date Assigned:	06/11/2014	Date of Injury:	08/19/2009
Decision Date:	07/21/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/27/2014

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 Physical Medicine and Rehabilitation 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 50-year-old male who reported an injury on 08/19/2009. The mechanism of injury was not specifically stated. Current diagnoses include right acromioclavicular joint arthropathy, mild left wrist tendonitis, L4-5 and L5-S1 discopathy, status post a lumbar fusion surgery in 2010 and status post a right knee arthroscopy in 2013. The injured worker was evaluated on 01/15/2014. The injured worker reported low back pain and right knee pain. Physical examination revealed swelling over the left thoracic spine area, tenderness over the paraspinal musculature, limited lumbar range of motion, spasms, 2+ deep tendon reflexes, tenderness over the medial aspect of the right knee, positive McMurray's testing and varus/valgus stress testing as well as slightly limited right knee flexion and a positive patellar grind maneuver on the right. The treatment recommendations at that time included the continuation of current medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLOBENZAPRINE 705MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The California MTUS Guidelines state that muscle relaxants are recommended as nonsedating second-line options for the short-term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. As per the documentation submitted, the injured worker has utilized cyclobenzaprine for an unknown duration. Despite ongoing use, the injured worker continues to demonstrate palpable muscle spasms. There is no frequency listed in the current request. Additionally, the request for cyclobenzaprine 705 mg is not medically appropriate. Therefore, the request is not medically certified.

HYDROCODONE/APAP (NORCO) 10/325MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids: Criteria For Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. The injured worker has utilized Norco 10/325 mg since 2012. There was no evidence of objective functional improvement. There was also no frequency listed in the current request. As such, the request is not medically certified.

OMEPRAZOLE 20MG, #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids, GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The California MTUS Guidelines state that proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factors and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the injured worker does not meet the criteria for the requested medication. Additionally, there is no frequency listed in the current request. As such, the request is not medically certified.

AMITRAMADOL DM (AMITRIPTYLINE/TRAMADOL/DEXTROMETHORPHAN 4/20/10% CREAM), 240G: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use, with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of a failure to respond to first-line oral medications prior to the initiation of a topical analgesic. There is also no frequency listed in the current request. As such, the request is not medically certified.

**GABAKETOLIDO (GABAPENTIN/KETOPROFEN/LIDOCAINE HCL 6/20/6.15%)
CREAM, 240GM:** Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use, with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Gabapentin is not recommended, as there is no evidence for the use of any antiepilepsy drug as a topical product. The only FDA-approved topical NSAID is Diclofenac. There is also no frequency listed in the current request. As such, the request is not medically certified.