

Case Number:	CM14-0034097		
Date Assigned:	06/20/2014	Date of Injury:	11/12/2002
Decision Date:	07/24/2014	UR Denial Date:	03/07/2014
Priority:	Standard	Application Received:	03/18/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 57 year old male who reported an injury to his low back. The clinical note dated 02/07/14 indicates the injured worker rating his low back pain as 9/10. Radiating pain was identified into the lower extremities. The injured worker also had complaints of dizziness and weakness. Upon examination, the injured worker demonstrated a positive straight leg raise at 50 degrees bilaterally. The injured worker was able to demonstrate 15 degrees of lumbar flexion with 10 degrees of extension and 10 degrees of bilateral tilt. Diminished strength was identified with plantar flexion. Decreased sensation was identified at the heel and foot. The clinical note dated 01/10/14 indicates the injured worker complaining of 8/10 pain with bilateral lower extremity radiculopathy, left greater than right. The note indicates the injured worker having been prescribed the use of Hydrocodone and Zolpidem at that time. The injured worker's urine drug screen revealed findings consistent with the drug regimen. The utilization review dated 12/04/13 resulted in denials for the use of Norco. The utilization review dated 03/03/14 resulted in denials for Alprazolam, Norco, Amitramadol transdermal application, as well as Gabapentin, Ketoprofen, and Lidocaine transdermal application. The clinical note dated 02/07/14 indicates the injured worker being prescribed numerous medications to address the ongoing low back pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Alprazolam ER QD #30, with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety.

Norco 10/325MG #90, with 3 refills: 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): 77.

Decision rationale: As noted in 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 insufficient documentation regarding the patient's functional benefits and functional improvement obtained with the continued use of narcotic medications. In addition, opioid risk assessments regarding possible dependence or diversion were also discussed. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establishes the efficacy of narcotics, this medication is not recommended as medically necessary at this time.

Amitramadol- DM transderm 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 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, CA MTUS, 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: which have 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.

Gabapentin 6%, ketoprofen 20%, lidocaine HCL 6.15%, transderm: 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: 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. This compound contains: which have 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.