

Case Number:	CM14-0034661		
Date Assigned:	06/20/2014	Date of Injury:	09/21/2004
Decision Date:	07/22/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/20/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 56-year-old man who sustained a work-related injury on September 21, 2004. Subsequently he developed chronic back and neck pain. The patient was diagnosed with the left shoulder impingement, cervical discopathy, lumbar sprain/strain and elbow epicondylitis. According to the note dictated on January 29, 2014, the patient was complaining of stabbing neck pain, shoulder and low back pain. The neck pain was radiating to the upper extremity with constant numbness and tingling. He was also complaining of severe back pain radiating to both lower extremities. His physical examination demonstrated good cervical tenderness with reduced range of motion, trapezius tenderness, lumbar tenderness with reduced range of motion, positive straight leg raise bilaterally. The patient has decreased sensation in lower extremities. He has shoulder tenderness with reduced range of motion. The patient was treated with topical analgesics since at least 2013 and pain medication including Hydrocodone, Tramadol and Flexeril without clear documentation of efficacy. The provider requested authorization for pain consultation and the medications mentioned below.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabaketilido Cream: Upheld

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

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

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no proven efficacy of topical application of the component of Gabaketilido cream (Gabapentin, Ketoprofen, and Lidocaine). Furthermore, oral form of these medications was not attempted, and there is no documentation of failure or adverse reaction from first line pain medications. The patient previously used topical analgesic without benefit. Therefore the request for Gabaketilido cream is not medically necessary.

Hydrocodone/APAP (x2 Refills): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179.

Decision rationale: According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules. These rules include prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy, the lowest possible dose should be prescribed to improve pain and function, and ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The 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. A satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. There is no clear evidence of objective and recent functional and pain improvement with previous use of opioids (Norco). There is no clear documentation of the efficacy/safety of previous use of Hydrocodone. There is no clear justification for the need to continue the use of Hydrocodone. Therefore, the Hydrocodone (x2 Refills) is not medically necessary.

Flexeril (x2 Refills): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Muscle Relaxant.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, page(s) 63 Page(s): 63.

Decision rationale: According to MTUS guidelines, Flexeril, a non sedating muscle relaxant, is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient in this case does not have clear recent evidence of spasm and the prolonged use of Flexeril is not justified. The patient was prescribed Flexeril at least since at least 2013 and there is no rational for continuous use of the drug is not justified. Therefore, the request of Flexeril is not medically necessary.

Amitramadol-UM Ultracream: Upheld

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

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

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111); topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no proven efficacy of topical application of the component of Amitramadol (Amitriptyline, Tramadol, and Dextromethorphan). Furthermore, oral form of these medications was not attempted, and there is no documentation of failure or adverse reaction from first line pain medications. The patient previously used topical analgesic without benefit. Therefore the request for Amitramadol cream is not medically necessary.

Pain Management Consultation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: The patient clinical evaluation and lumbar MRI findings did not support the diagnosis of radiculopathy. The patient physical examination showed low back pain radiating to both lower extremities with lumbar tenderness and reduced range of motion. There is a positive straight leg raise with decreased lower extremity sensation and without root distribution. There are no focal neurological findings. There is no clinical evidence of radiculopathy with corroboration from diagnostic studies. Therefore, the request for Pain Management Consultation for Lumbar Epidural Steroid Injection is not medically necessary.

