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| Case Number: | CM14-0042518 | | |
| Date Assigned: | 06/30/2014 | Date of Injury: | 12/17/2002 |
| Decision Date: | 09/30/2014 | UR Denial Date: | 03/26/2014 |
| Priority: | Standard | Application Received: | 04/09/2014 |

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 and 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 54-year-old male who reported an injury on 12/17/2002 and 12/19/2013 due to cumulative injuries. The injured worker had a history of neck pain, back pain, and right knee pain. The injured worker had diagnoses of cervical disc protrusion, lumbar spine disc protrusion, and right knee pain, questionable internal derangement of the right knee. The past surgical procedures included status post anterior fusion and status post laminectomy with residual. Past treatments included pain management, medication, and physical therapy. The objective findings dated 03/03/2014 revealed positive for neck pain, positive for muscle and joint pain related to the back, and trauma. Neurologically, positive for dizziness and fainting. The examination of the cervical spine revealed slight decreased range of motion with flexion of 40 degrees and extension of 50 degrees, decreased strength and sensation bilaterally at 4/5 at the C5, C6, C7, and C8, and deep tendon reflexes were 1++ bilaterally. Examination of the lumbar spine revealed decreased range of motion with flexion at 45 degrees and extension 10 degrees, positive straight leg raise on the right at 60 degrees, tenderness to the paraspinals equally, normal strength 5/5 bilaterally at the L4-5 and S1, normal sensation at 5/5 on the left and at the L4, L5, and S1 with decreased sensation at 4/5 at the L4-5 with 5/5 sensation on the right, and deep tendon reflexes were 1+ 1++ bilaterally at the patellar and Achilles tendon. The treatment plan included to continue treatment with spinal surgeon, request for Kera-Tek gel, and return to clinic in 4 weeks. The Request for Authorization dated 06/30/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50mg #90: 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 Tramadol, Ongoing management Page(s): 82, 93, 94, 113, 78.

Decision rationale: The request for Ultram 50mg #90 is not medically necessary. The California MTUS indicate that Central analgesics drugs such as Tramadol (Ultram) are reported to be effective in managing neuropathic pain and it is not recommended as a first-line oral analgesic. California MTUS recommend that there should be documentation of the 4 A's for Ongoing Monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The clinical notes were not evident of documentation that included activities of daily living, adverse side effects and any aberrant drug behavior. The guidelines indicate that tramadol should not be the first line of oral analgesics. The request did not address frequency. As such, the request is not medically necessary.

Kera-Tek Gel 4 oz: 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 Topical Analgesics , Ketoprofen Page(s): 111, 112.

Decision rationale: The request for Kera-Tek gel 4 oz is not medically necessary. The California MTUS guidelines indicate that Ketoprofen is a non FDA-approved agent for a topical application. The request did not indicate the frequency. As such, the request is not medically necessary.