

Case Number:	CM14-0081572		
Date Assigned:	07/18/2014	Date of Injury:	10/28/2003
Decision Date:	10/02/2014	UR Denial Date:	05/26/2014
Priority:	Standard	Application Received:	06/02/2014

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 58 year old male who reported an injury on 10/26/2003 from a fall. The injured worker was diagnosed with lumbar sprain. The injured worker was treated with medications. The injured worker had no indication of diagnostic studies or surgical history in the medical records. On the clinical note dated 04/05/2014, the injured worker complained of back pain that radiated to bilateral lower extremities rated 5-6/10 and 8/10 without medications. The injured worker had bilateral tenderness and spasms of the L3-5 paraspinal muscles and decreased range of motion to lumbar spine with extension 10 degrees, flexion 50 degrees, bilateral lateral bending 20 degrees, and rotation 30 degrees. The injured worker stated he was unable to perform activities of daily living. The injured worker was prescribed Norco three times a day, Levitra 20mg daily, remeron 15mg at bedtime, ultram ER 150mg 1-2 a day, ketoprofen crme 20% three times a day, theramine three times a day, sentra pm twice a day, and sentra am twice a day. The treatment plan was for remeron 15mg at bedtime and ketoprofen cream 20% three times a day. The rationale for the request was for the ketoprofen cream to aid the tapering of the narcotics. The request for authorization was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Remeron15mg QHS #30: 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 Antidepressants for chronic pain Page(s): 13-16.

Decision rationale: The request for Remeron 15mg QHS #30 is not medically necessary. The injured worker is diagnosed with lumbar sprain. The injured worker complains of back pain that radiated to bilateral lower extremities rated 5-6/10 and 8/10 without medications. The California MTUS guidelines recommend antidepressants as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. The medical records lack documentation of the efficacy of the medication. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The requesting physician did not provide documentation of decreased pain. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request for Remeron 15mg QHS #30 is not medically necessary.

Ketoprofen Cream 20% TID #3: 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 Page(s): 111-112.

Decision rationale: The request for Ketoprofen cream 20% TID #3 is not medically necessary. The injured worker is diagnosed with lumbar sprain. The injured worker complains of back pain that radiated to bilateral lower extremities rated 5-6/10 and 8/10 without medications. The California MTUS guidelines primarily recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Non-steroidal anti-inflammatory agents Recommended for short-term use 4-12 weeks. The medical records lack documentation of efficacy of the medication. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The requesting physician did not provide documentation decreased pain with the medication. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which the medication is to be applied in order to determine the necessity of the medication. As such, the request for Ketoprofen cream 20% TID #3 is not medically necessary.