

Case Number:	CM14-0081754		
Date Assigned:	07/18/2014	Date of Injury:	05/11/2012
Decision Date:	09/18/2014	UR Denial Date:	05/20/2014
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, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 38-year-old male who has submitted a claim for lumbar disc protrusions, bilateral Baker's cysts, and sprain/strain of the right shoulder, bilateral knees, and lumbar spine; associated with an industrial injury date of 05/11/2012. Medical records from 2012 to 2014 were reviewed and showed that patient complained of low back, right shoulder, and bilateral knee pain. Physical examination showed tenderness over the right acromioclavicular joint, bilateral prepatellar area, and lumbar paravertebral region. Range of motion of the right shoulder and lumbar spine was decreased. Spasms were noted in the lumbar paravertebral muscles. Straight leg raise test was negative. Facet loading was positive in the lower lumbar area. Deep Tendon Reflexes (DTRs) and motor testing were normal. Sensation was intact. Treatment to date has included medications, and physical therapy. A utilization review, dated 05/20/2014, denied the retrospective request for tizanidine because guidelines do not recommend its use with NSAIDs; denied the retrospective requests for Amitriptyline/Dextromethorphan/Tramadol and Diclofenac/Flurbiprofen compound creams because guidelines do not support the use of custom compound creams; and denied the retrospective requests for chromatography because the patient was not taking any prescription medication at the time of the 06/20/2012 evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHROMATOGRAPHY DRUG SCREEN: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Urine Drug Testing.

Decision rationale: Per the Official Disability Guidelines, (ODG) "Laboratory-based specific drug identification, which includes; gas chromatography/mass, spectrometry (GC/MS) or liquid chromatography tandem mass spectrometry (LC/MS/MS) are used for confirmatory testing of drug use. These tests allow for identification and quantification of specific drug substances. They are used to confirm the presence of a given drug, and/or to identify drugs that cannot be isolated by screening tests. These tests are particularly important when results of a test are contested. In this case, the patient complained of low back, right shoulder, and bilateral knee pain. A baseline urine drug screening performed on 06/20/2012 was negative for all drugs tested, since the patient was not taking medication at that time. However, there was no evidence that the patient was at risk for aberrant drug use behavior that may warrant drug testing, and there is no given rationale for chromatography drug testing. Lastly, the present request as submitted failed to specify the drugs to be tested. Therefore, the request for Chromatography Drug Screen is not medically necessary.

TIZANIDINE HCL 4MG, #30: Overturned

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

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

Decision rationale: CA MTUS guidelines state that, "Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. They also show no benefit beyond NSAIDs in pain and overall improvement." MTUS also states that "Tizanidine is a centrally acting alpha 2-adrenergic agonist that is FDA approved for management of spasticity and myofascial pain." In this case, the patient complains of low back, right shoulder, and bilateral knee pain. On physical examination, spasms were noted in the lumbar paravertebral muscles. The medical necessity has been established. Therefore, the request for Tizanidine HCL 4mg, #30 is medically necessary.

AMITRIPTYLINE/DEXTROMETHORPHAN/TRAMADOL (PERCENTAGES UNKNOWN), 240GM: 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): 111-113.

Decision rationale: As stated on CA MTUS guidelines, "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are recommended as an option for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Regarding the amitriptyline component, guidelines support its use with baclofen and ketamine in cancer patients for treatment of chemotherapy-induced peripheral neuropathy." CA MTUS and ODG do not specifically address Dextromethorphan. Guidelines do not support the use of Tramadol in a topical formulation. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the patient complains of low back, right shoulder, and bilateral knee pain. However, there was no discussion regarding intolerance to or failure of oral formulations. Moreover, the medical records do not show evidence of chemotherapy-induced peripheral neuropathy. Furthermore, guidelines do not support the use of topical tramadol. Therefore, the request for Amitriptyline/Dextromethorphan/Tramadol (Percentages Unknown), 240gm is not medically necessary.

DICLOFENAC/FLURBIPROFEN (PERCENTAGES UNKNOWN), 240GM: 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): 111-113.

Decision rationale: As stated on the CA MTUS guidelines, "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are recommended as an option for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical Diclofenac is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day. Topical NSAID formulation is only supported for Diclofenac in the California MTUS. In this case, the patient complains of low back, right shoulder, and bilateral knee pain. However, the medical records reviewed did not show failure of or intolerance to oral formulations. Moreover, topical flurbiprofen is not recommended. Furthermore, topical baclofen has not been evaluated for topical use of the spine, and shoulder. Therefore, the request for Diclofenac/Flurbiprofen (Percentages Unknown), 240gm is not medically necessary.