

Case Number:	CM14-0082889		
Date Assigned:	07/21/2014	Date of Injury:	08/08/2011
Decision Date:	09/03/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	06/03/2014

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 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 60-year-old male who reported an injury on 08/08/2011 caused by an unspecified mechanism. The injured worker's treatment history included medications, epidural steroid injections and a magnetic resonance imaging (MRI), and electromyography/nerve conduction study (EMG/NCS). The injured worker was evaluated on 04/23/2014 and it was documented that the injured worker complained of low back pain and right shoulder pain. It was documented that the pain had increased. Pain with medications was a 5/10 and without medication was an 8/10. The injured worker complained lower extremity tingling sensation. Objective findings of cervical spine there was increased pain. There was facet joint stiffness, range of motion painful and limited, lumbar spine there was tenderness to palpation over the spinous process and range of motion was limited. Lumbar spine of the lower extremity appeared to be grossly intact. Shoulder tenderness, but pain was increased with extension of the shoulder joint. Right shoulder no tenderness, but there was increased pain with extension of the shoulder joint. Diagnoses included gastritis, right shoulder pain, lower back pain, hip pain, leg pain. Medications included hydrocodone 10/325 mg and compound cream. The Request for Authorization dated 05/23/2014 was for hydrocodone/BIT/ACET 10/325 mg and compound cream, Flurbiprofen 25%, tramadol 15%; however, the rationale was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocod/BIT/ACET 10/325MG, count 60.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines When to Discontinue Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Criteria for Use, On-going Management) Page(s): 78.

Decision rationale: The request for Hydrocodone/BIT/ACET 10/325 mg # 60 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. The provider indicated the injured worker had a urine drug screen showing compliance however, that was not submitted for this review. The provider noted the injured worker having improved function while on medications however, the provider failed to indicate long-term functional goals. In addition, the request did not indicate a frequency of medication. Therefore, the request is not medically necessary.

Compound Cream (Flurbiprofen 25%, Tramadol 15%): Upheld

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

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

Decision rationale: The requested is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product contains at least one drug (or drug class) that is not recommended. The guidelines state that there are no other commercially approved topical formulation of lidocaine (whether creams, lotions, or gels) that are indicated for neuropathic pain other than Lidoderm. The proposed gel contains methyl salicylate and menthol. The documentation submitted failed to indicate the injured worker's conservative care measures such as, physical therapy and pain medicine management outcome measurements. In addition, request did not provide frequency or location where the compound medication will be applied. As such, the request for compound cream (Flurbiprofen 25%, Tramadol 15%) is not medically necessary.