

Case Number:	CM14-0083430		
Date Assigned:	07/21/2014	Date of Injury:	09/30/2002
Decision Date:	09/17/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	06/05/2014

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 Physical Medicine and Rehabilitation and Pain Management, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 62-year-old female with date of injury of 09/30/2002. The listed diagnoses per the treating physician dated 04/09/2014 are disk protrusion at L2-L3, L3-L4, and L5-S1, disk herniation at L4-L5, 4 to 5 mm with severe spinal stenosis, severe facet arthropathy at L3-L4, L4-L5, and L5-S1, bilaterally, mild spinal stenosis at L3-L4 and L5-S1, bilateral L4-L5 radiculopathy, obesity, Chronic low back pain and Insomnia secondary to pain. According to this report, the patient complains of constant low back pain that she rates 6/10 with radiation to the bilateral lower extremities. She reports associated numbness, tingling, and pulling sensation in the posterior aspect of the lower extremities. She notes that her low back feels better since her last visit. Bowel movement is normal with Senokot-S. The quality of her life is limited secondary to pain. Phenergan 50 mg and tramadol provide her with 50% symptomatic relief. She reports constipation with medication use. She continues to utilize her TENS unit. The physical examination reveals bilateral dull diminished sensory findings at the L4 and L5 dermatomes with all remaining dermatomes intact. Deep tendon reflexes are 1+ at the bilateral L4 and 2+ at the bilateral S1 nerve root. Lumbar spine range of motion is restricted. Straight leg raise and Kemp's testing is positive bilaterally. Motor strength is 4/5 bilaterally in the extensor hallucis longus and tibial anterior muscle groups. Otherwise, strength is 5/5 in all remaining motor nerves.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 1 prescription of trazodone 50 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-15. Decision based on Non-MTUS Citation (ODG) Sedating antidepressants.

Decision rationale: This patient presents with chronic low back pain. The treating physician is requesting trazodone 50 mg. The treating physician does not explain what this medication is to be used for but it would appear that it is prescribed for insomnia. The MTUS Guidelines page 13 to 15 do support the use of antidepressants for neuropathic pain. In regards to its use for insomnia, ODG guidelines support it if concurrent depression is documented. In this case, the treating physician does not explain why Trazodone is being prescribed. While insomnia is listed as one of the diagnosis, there is no discussion regarding what has been tried and how the patient is struggling with insomnia. There is no discussion regarding any depression either. As such, the request is not medically necessary.

Prospective request for 1 prescription of flurbiprofen 20% cream, 120 gm: Upheld

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

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

Decision rationale: This patient presents with chronic low back pain. The treating physician is requesting flurbiprofen 20% cream. The MTUS Guidelines page 111 on topical analgesics state that it is largely experimental in use with few randomized control trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical NSAIDs are indicated for patients with osteoarthritis and tendonitis particularly that of the knee, elbow, and other joints that are amenable to topical treatment. It is recommended for short term use between 4 to 12 weeks. In addition, MTUS does not support the use of topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder. While the patient has not tried flurbiprofen in the past, it appears that the treating physician is requesting this cream for the patient's low back pain, which is not supported by the guidelines. As such, the request is not medically necessary.

Prospective request for 1 prescription of ketoprofen 20%/ketamine 10% cream, 120 gm: Upheld

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

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

Decision rationale: This patient presents with chronic low back pain. The treating physician is requesting ketoprofen 20%/ketamine 10% cream. The MTUS Guidelines page 111 on topical analgesics state that it is largely experimental in use with few randomized control trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS further states, Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, ketoprofen is currently not approved for topical application. As such, the request is not medically necessary.

Prospective request for 1 prescription of gabapentin 10%/cyclobenzaprin 10%/capsaicin 0.0375% cream, 120 gm: Upheld

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

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

Decision rationale: This patient presents with chronic low back pain. The treating physician is requesting a compound cream gabapentin/ cyclobenzaprine/capsaicin. The MTUS Guidelines page 111 on topical analgesics state that it is largely experimental in use with few randomized control trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS further states, Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, gabapentin and cyclobenzaprine are not recommended in topical formulation. As such, the request is not medically necessary.