

Case Number:	CM14-0084323		
Date Assigned:	07/21/2014	Date of Injury:	08/10/2013
Decision Date:	08/29/2014	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 & Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in Texas & Oklahoma. 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 32-year-old female who reported an injury on 06/10/2013. The mechanism of injury was not provided for clinical review. The diagnoses included lumbar spine sprain/strain, abdominal pain rule out incisional hernia, discogenic spondylosis L5-S1, and disc herniation at L5-S1. The previous treatments included electromyography (EMG) and medication. The diagnostic imaging included an MRI. Within the clinical note dated 05/06/2014, it was reported the injured worker complained of constant lower back pain. She reported the pain to be moderate to severe. The injured worker reported having numbness, tingling, and pain radiating down her legs. Upon the physical examination, the provider noted the injured worker to have tenderness to palpation with spasms over the paraspinals bilaterally and tenderness to palpation of the bilateral sacroiliacs. The injured worker had limited range of motion secondary to pain. The provider indicated the injured worker had a positive sitting root test. The request submitted is for Capsaicin/Flurbiprofen/Tramadol/Menthol/Camphor and Amitriptyline/Dextromethorphan/Tramadol however, a rationale was not provided for clinical review. The request for authorization was submitted and dated on 05/06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Capsaicin 0.025% Flurbiprofen 15% Tramadol 15% Menthol 2% Camphor 2%- 240gm:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The injured worker complained of constant lower back pain which she reported was moderate to severe. She complained of tingling and pain radiating down her legs. The California MTUS Guidelines recommend topical NSAIDs for the use of osteoarthritis and tendonitis, in particular, that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis for the treatment of the hips or spine. Capsaicin is only recommended as an option in patients who have not responded or intolerant to other treatments. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first line oral analgesic. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the treatment site. The request submitted failed to provide the frequency of the medication. Therefore, the request for Capsaicin 0.025% Flurbiprofen 15% Tramadol 15% Menthol 2% Camphor 2%- 240gm is not medically necessary.

Amitriptyline 4% Dextromethorphan 10% Tramadol 20%- 240gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The injured worker complained of constant lower back pain which she reported was moderate to severe. She complained of numbness, tingling, and pain radiating down her legs. The California MTUS Guidelines note topical NSAIDs are recommended for the use of osteoarthritis and tendonitis, in particular, that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. Tramadol is a centrally acting synthetic opioid and it is not recommended as a first line oral analgesic. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The request submitted failed to provide the treatment site. Therefore, the request for Amitriptyline 4% Dextromethorphan 10% Tramadol 20%- 240gm is not medically necessary.