

Case Number:	CM14-0086354		
Date Assigned:	08/08/2014	Date of Injury:	09/26/2013
Decision Date:	09/11/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	06/09/2014

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 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 injured worker is a 59 year old male who sustained work related injuries on 09/26/13. Clinical documentation submitted for review referenced prior medical conditions from several years ago. There was reference and single note that the injured worker sustained injury to the low back as a result of lifting. He is noted to have low back pain radiating in the right lower extremity. Per utilization review determination dated 05/23/14 the injured worker presented with injuries to the right knee, right ankle, right foot, right heel, and lumbar spine. Physical examination revealed decreased lumbar range of motion, tenderness of paraspinal muscles, and pain with knee range of motion. MRI of the lumbar spine dated 01/31/14 revealed disc desiccation at L3-4, L4-5, and L5-S1. There was grade 1 retrolisthesis of L5 over S1. Right knee MRI dated 01/31/14 revealed small knee joint effusion with fluid extending into the suprapatellar bursa. MRI of the right hip dated 01/31/14 is reported as unremarkable. MRI of the right ankle dated 01/31/14 revealed tenosynovitis of the flexor hallucis longus tendon. Current diagnosis included lumbar spine disc protrusion, right hip sprain strain, right knee bursitis/joint effusion, and right ankle tenosynovitis of the flexor hallucis longus tendon. Treatment to date included oral medications, physical therapy, and acupuncture. Utilization review determination dated 05/23/14 non-certified the request for tramadol ER 150mg #30, Methoderm gel 360g, cyclobenzaprine 7.5mg #90, pain management consultation, orthopedic consultation, podiatry consultation for right ankle/foot/heel, electro shockwave therapy one times six, Gabapentin 10% Amitriptyline 10% Dextromethorphan 10% cream, and Acupuncture two times four.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 150 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIATES Page(s): 74-80.

Decision rationale: The request for tramadol ER 150mg #30 is not supported as medically necessary. No clinical records were available for review pertaining to the mechanism of injury and subsequent treatment. As such given the complete absence of clinical records pertaining to the injuries, the medical necessity for tramadol ER 150mg #30 is not established.

Menthoderm Gel 360 gm: 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): 111-112.

Decision rationale: The request for Mentoderm gel 360g is not supported as medically necessary. Per CAMTUS and Official Disability Guidelines topical analgesics are largely considered experimental/investigational due to the lack of high quality peer reviewed literature establishing the efficacy of these topical applications.

Cyclobenzaprine 7.5 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66.

Decision rationale: The request for cyclobenzaprine 7.5mg #90 is not supported as medically necessary. No current treating no current records from treating provider were available for review. As such there is no objective data to establish that the injured worker has myospasms for which this medication would be indicated.

Pain management consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Page 127.

Decision rationale: The request for pain management consultation is not supported as medically necessary. No clinical records were submitted for review. As such the medical necessity for a pain management consultation cannot be established.

Orthopedic consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Page 127.

Decision rationale: The request for orthopedic consultation is not supported as medically necessary. No clinical records pertaining to the claimant or injured worker treatment for the work related conditions was submitted. As such the medical necessity for orthopedic surgeon cannot be established.

Podiatry consultation for right ankle/foot/heel: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Page 127.

Decision rationale: The request for podiatry consultation for right ankle/foot/heel is not supported as medically necessary. No clinical records were submitted for review. As therefore in the absence of objective findings of foot dysfunction medical necessity is not established.

ESWT 1 x 6 (extracorporeal shock wave therapy): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Gerdesmeyer (2003) literature.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, ESWT.

Decision rationale: The request for extra corporeal shockwave treatments one times six is not supported as medically necessary. No clinical records from the treating provider were presented for review. Therefore it is unknown which body part the provider is requesting shockwave therapy for.

Gabapentin 10% Amitriptyline 10% Dextromethorphan 10%cream (quantity not specified): 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): 111-114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Compounded Medications.

Decision rationale: The request for Gabapentin 10% Amitriptyline 10% Dextromethorphan 10% cream is not supported as medically necessary. California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: Gabapentin 10% Amitriptyline 10% which have not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended, and therefore not medically necessary.

Acupuncture 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture two times four is not supported as medically necessary. The injured worker previously received acupuncture. The number of visits and response to treatment is not documented and therefore additional acupuncture two times four is not supported as medically necessary.

Flurbiprofen 20% Tramadol 20% Cyclobenzaprine 4% cream (quantity not specified): 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): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Compounded Medications.

Decision rationale: The request for Flurbiprofen 20% Tramadol 20% Cyclobenzaprine 4% Cream is not medically necessary. California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: Flurbiprofen 20% Tramadol 20% Cyclobenzaprine 4% which have not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended, and therefore not medically necessary.