

Case Number:	CM14-0087869		
Date Assigned:	07/23/2014	Date of Injury:	07/21/2013
Decision Date:	09/08/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/12/2014

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 Texas. 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 47 year old male injured on 07/21/13 due to an undisclosed mechanism of injury. Current diagnosis include lumbar spine disc herniation at L5-S1, right lower extremity radicular pain, acute cervical sprain rule out disc herniation, bilateral upper extremity radicular pain with neurologic findings, and underlying psychiatric issues. Clinical note dated 06/23/14 indicates the injured worker presented complaining of cervical spine and lumbar spine pain. The injured worker reports lumbar spine pain radiating to the right lower extremity. The injured worker rated pain at 6-8/10 depending on location. Physical examination of the cervical spine revealed tenderness to palpation bilaterally over the cervical paraspinal muscles and bilateral upper trapezius muscles, full active range of motion in all planes, neurovascular status is intact distally with no evidence of gross motor or sensory deficits. Examination of the lumbar spine revealed tenderness to palpation, range of motion limited due to pain, neurovascular status intact distally, bilateral sitting straight leg raising was positive in the right lower extremity and negative in the left lower extremity. Medications include Tylenol #3. The initial request for Kara-Tek analgesic gel, flurbiprofen 20%/cyclobenzaprine 10%/mentho 4% cream qty 180gm and Tylenol #3 (codeine 30/acetaminophen 300) quantity 30, was non-certified on 05/30/14. 9203

IMR ISSUES, DECISIONS AND RATIONALES

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

Kara-Tek Analgesic Gel: Upheld

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

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore Kara-Tek Analgesic Gel cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Flurbiprofen 20%/Cyclobenzaprine 10%/Mentho 4% Cream, QTY: 180g: Upheld

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

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore Flurbiprofen 20%/Cyclobenzaprine 10%/Mentho 4% Cream, QTY: 180g cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Tylenol No. 3 (Codeine 30/Acetaminophen 300), QTY: 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Tylenol No. 3 (Codeine 30/Acetaminophen 300), quantity: 30 cannot be established at this time.