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| Case Number: | CM14-0099533 | | |
| Date Assigned: | 07/28/2014 | Date of Injury: | 04/16/2008 |
| Decision Date: | 08/29/2014 | UR Denial Date: | 06/19/2014 |
| Priority: | Standard | Application Received: | 06/30/2014 |

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 Occupational Medicine 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:

This is a 52-year-old male with a 4/16/08 date of injury. The mechanism of injury was not noted. According to a 6/3/14 progress note, the patient complained that the pain in his lower back has worsened after heavy lifting from helping a friend move. He rated his pain 5/10 on a pain scale of 0-10. The pain was located mostly in his right axial lower back without radiation into the extremity. Objective findings: antalgic gait, significant tenderness to palpation in bilateral lumbar paraspinal muscle groups and the right buttock with palpable bands and trigger points. Diagnostic impression: low back pain, lumbosacral spondylosis without myelopathy, myofascial pain, lumbar or thoracic radiculitis/radiculopathy. Treatment to date: medication management, activity modification, physical therapy, TENS unit, facet joint injections. A UR decision dated 6/19/14 denied the requests for Tramadol and Compound cream (lidocaine, flurbiprofen, gabapentin, versapro, cyclobenzaprine). A specific rationale for the denials was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg by mouth three times a day: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going Management, Opioids Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. In addition, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring. Furthermore, the quantity of medication requested was not documented in this request. Therefore, the request for Tramadol 50mg by mouth three times a day is not medically necessary.

Compound cream(lidocaine, flurbiprofen, gabapentin, versapro, cyclobenzaprine): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 25, 28, 111-113.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Neither lidocaine, flurbiprofen, cyclobenzaprine, nor gabapentin are supported by guidelines for topical use in a cream formulation. A specific rationale identifying why this product would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Compound cream (lidocaine, flurbiprofen, gabapentin, versapro, cyclobenzaprine) is not medically necessary.