

Case Number:	CM14-0186929		
Date Assigned:	11/18/2014	Date of Injury:	10/25/2013
Decision Date:	01/06/2015	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	11/10/2014

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 Family Medicine and is licensed to practice in New Jersey. 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 61-year-old female who reported an injury on 10/25/2013. The mechanism of injury involved a fall. The current diagnoses include lumbar radiculopathy, lumbar spine displacement, lumbar spine stenosis, internal derangement of the right shoulder, rotator cuff syndrome of the right shoulder, shoulder sprain/strain, internal derangement of the bilateral knees and bilateral knee sprain/strain. The injured worker presented on 09/25/2014, with complaints of 7/10 pain in the lumbar spine, 6/10 pain in the right shoulder, and 8/10 pain in the bilateral knees. Physical examination revealed painful lumbar range of motion, 40 degrees flexion, 20 degrees extension, 20 degrees right and left rotation, 15 degrees right and left lateral bend, painful shoulder range of motion, positive impingement sign on the right, and positive anterior drawer testing at the bilateral knees. Previous conservative treatment is noted to include rest, medication management, and trigger point injections. The treatment recommendations included continuation of the current medication regimen, 12 sessions of acupuncture, and 12 sessions of physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription for Ultram 150 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. There is no documentation of a failure of non-opioid analgesics prior to the initiation of the current medication. Additionally, previous urine toxicology reports are inconsistent with the current medication regimen. There was also no frequency listed in the current request. As such, the request is not medically appropriate.

1 Prescription for Norco 10/325 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. There is no documentation of a failure of non-opioid analgesics prior to the initiation of the current medication. Additionally, previous urine toxicology reports are inconsistent with the current medication regimen. There was also no frequency listed in the current request. As such, the request is not medically appropriate.

1 Prescription for Flurbiprofen 20%/Tramadol 20% 210 gm with 1 refill: Upheld

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

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

Decision rationale: The California MTUS Guidelines, state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The only FDA approved topical NSAID is Diclofenac. Therefore, the request for a compounded cream with Flurbiprofen 20% is not medically appropriate. There is also no frequency noted in the request. As such, the request is not medically appropriate.

1 Prescription for Terocin patches #30: Upheld

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

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

Decision rationale: The California MTUS Guidelines state, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of a failure of first line oral medication prior to the initiation of a topical analgesic. There is also no frequency listed in the request. As such, the request is not medically appropriate.