

Case Number:	CM14-0196595		
Date Assigned:	12/04/2014	Date of Injury:	12/20/2006
Decision Date:	01/27/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	11/24/2014

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:

Patient is a 57 year-old male with date of injury 12/20/2006. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 10/22/2014, lists subjective complaints as low back pain with radicular symptoms down the right extremity. Objective findings: Examination of the lumbar spine revealed tenderness to palpation of the paraspinal muscles with 1+ palpable muscle spasm from L4-L5. Negative twitch response. Range of motion was limited in all directions. Positive straight leg raise at 50 degrees on the right and negative on the left. Sensory exam revealed hypesthesia in the right L5 and S1 dermatomes. Diagnosis: 1. Chronic low back pain with muscle spasms 2. Multilevel lumbar disc bulge with degenerative disc disease and facet arthropathy 3. Lumbar radiculopathy, lower right extremity. Provider noted that the patient had recently submitted to a random drug screen and was found to be compliant. The medical records supplied for review document that the patient has been taking the Morphine and Norco for at least as far back as six months. The KGL cream was prescribed on 10/22/2014. Medication: 1. Morphine ER 60mg, #60 SIG: Q122. Norco 10/325mg, #180 SIG: Q4H PRN3. KGL Cream (Ketoprofen 15%/ Gabapentin 10%/ Lidocaine 10%) 240 grams SIG: topical, twice daily.

IMR ISSUES, DECISIONS AND RATIONALES

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

Morphine ER 60mg quantity 60 that was provided on 10/22/2014: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 80.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. The MTUS states that opioids may be continued, (a) If the patient has returned to work, or (b) If the patient has improved functioning and pain. There is good documentation in the primary treating physician's appeal letter that the patient has considerable improvement in his ADLs and level of pain on the current medication regimen. I am reversing the previous utilization review decision. Morphine ER 60mg quantity 60 that was provided on 10/22/2014 is medically necessary.

Norco 10/325mg quantity 180 that was provided on 10/22/2014: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 80.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. The MTUS states that opioids may be continued, (a) If the patient has returned to work, or (b) If the patient has improved functioning and pain. There is good documentation in the primary treating physician's appeal letter that the patient has considerable improvement in his ADLs and level of pain on the current medication regimen. I am reversing the previous utilization review decision. Norco 10/325mg quantity 180 that was provided on 10/22/2014 is medically necessary.

KGL cream (Ketoprofen 15% Gabapentin 10% Lidocaine 10%) 240gms that was provided on 10/22/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 111-112.

Decision rationale: The compound contains ketoprofen and is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis and is not recommended by the MTUS. KGL cream (Ketoprofen 15% Gabapentin 10% Lidocaine 10%) 240gms that was provided on 10/22/2014 is not medically necessary.

Urine drug screening 4 times a year: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 43.

Decision rationale: The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. Screening is recommended at baseline, randomly at least twice and up to 4 times a year and at termination. The drug screen requested falls within the criteria listed above. I am reversing the previous utilization review decision. Urine drug screening 4 times a year is medically necessary