

Case Number:	CM14-0199626		
Date Assigned:	12/10/2014	Date of Injury:	10/28/2008
Decision Date:	02/04/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/01/2014

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 Practice, and is licensed to practice in Utah. 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 patient is a 68 year-old female. The patient's date of injury is 10/28/2008. The mechanism of injury was trying to pull a lip up and when it wouldn't move, she pulled harder, sustaining a reported injury to the lumbosacral spine, right hip and psyche. The patient has been diagnosed with degenerative disc disease of the lumbar spine with radiculopathy, lumbar facet hypertrophy, right hip arthralgia, and coping issues. The patient's treatments have included injections, psych consultation, imaging studies, pain management, and medications. The physical exam findings dated 6/4/2014 states she has right greater than left lumbosacral tenderness. She has a limited lumbar range of motion with movement. She has a negative FABER test bilaterally. There is diminished sensation of the right dermatome. Motor exam shows a true weakness of the right TA, Psoas and EHL. The patient's medications have included, but are not limited to, Norco, Flexeril, Tramadol, Ambien and Senna. The request is for Tramadol and Ketoprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol HCL Tab 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49, Chronic Pain Treatment Guidelines Opioids; Opioids, criteria for use Page(s): 78; 93-94; 80. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 115

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 75-79.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS indicates that ongoing management of opioids includes documentation of prescriptions given from a single practitioner, prescriptions from a single pharmacy and the lowest dose should be used to improve function. There should also be an ongoing review of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug behaviors. According to the clinical documents, it is unclear that the medications are from a single practitioner or a single pharmacy. Some documentation of analgesia is noted. Documentation for activities of daily living, adverse side effects, and aberrant drug usage is unclear at this time. There is no clear functional gain that has been documented with this medication. Tramadol has been previously approved for a weaning taper. There has been no tapering of this medication. According to the clinical documentation provided and current MTUS guidelines; Tramadol is not indicated as a medical necessity to the patient at this time.

Ketoprofen 20% Gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Ketoprofen gel. MTUS guidelines state the following: Non FDA-approved agents: Ketoprofen gel: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. According to the clinical documentation provided and current MTUS guidelines; Ketoprofen gel is not indicated as a medical necessity to the patient at this time.