

Case Number:	CM15-0109806		
Date Assigned:	06/16/2015	Date of Injury:	07/14/2014
Decision Date:	08/31/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	06/08/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Most of the office visit reports were illegible. The injured worker is a 33 year old male who sustained an industrial/work injury on 7/14/14. He reported an initial complaint of neck and back pain. The injured worker was diagnosed as having thoracic sprain-strain, cervical sprain-strain, contusion of elbow, lumbar spine strain. Treatment to date includes medication, physical therapy, chiropractic care, activity modification, and transcutaneous electrical nerve stimulation (TENS) unit with therapy. MRI results of the lumbar spine were reported on 10-9-14 and cervical spine on 2-13-15. EMG-NCV (electromyography and nerve conduction velocity test) on 1-15-15 reveals mild right carpal tunnel syndrome. Currently, the injured worker complained of low back pain rated 7 out of 10 that radiated to the left lower extremity and cervical spine pain rated 6 out of 10 that radiated to the left upper extremity. Per the primary physician's report (PR-2) on 4/7/15, exam revealed slow gait, tenderness, spasm, decreased range of motion, 4+ out of 5 strength about the left quadriceps, left eversion, decreased sensation in the L5-S1 dermatomes, positive straight leg raise bilaterally, 4+ out of 5 strength in the left wrist and decreased sensation at C6-7 dermatomes. The requested treatments include Cyclobenzaprine 7.5mg, Tramadol 150mg, and compound cream Ketoprofen 10% base 300gms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

Decision rationale: The injured worker sustained a work related injury on 7/14/14. The medical records provided indicate the diagnosis of thoracic sprain-strain, cervical sprain-strain, contusion of elbow, lumbar spine strain. Treatments have included medication, physical therapy, chiropractic care, activity modification, and transcutaneous electrical nerve stimulation (TENS) unit with therapy. The medical records provided for review do not indicate a medical necessity for Cyclobenzaprine 7.5mg #90. The MTUS recommends the muscle relaxant non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic low back pain. Cyclobenzaprine is a muscle relaxant with a recommended dosing of 5 to 10 mg three times a day, for not longer than 2-3 weeks. The medical records indicate the injured worker has been on this medication at least since 01/2015. This exceeds the guidelines recommendation, therefore not medically necessary.

Tramadol 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Online Version.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-88.

Decision rationale: The injured worker sustained a work related injury on 7/14/14. The medical records provided indicate the diagnosis of thoracic sprain-strain, cervical sprain-strain, contusion of elbow, lumbar spine strain. Treatments have included medication, physical therapy, chiropractic care, activity modification, and transcutaneous electrical nerve stimulation (TENS) unit with therapy. The medical records provided for review do not indicate a medical necessity for Tramadol 150mg #30. Tramadol is a synthetic opioid. The MTUS recommends the use of the lowest dose of opioids for the short term treatment of moderate to severe pain. The MTUS states that there is no high quality study supporting the use of Tramadol for more than three months. Also, the MTUS recommends that individuals on opioid maintenance treatment be monitored for analgesia (pain control), activities of daily living, adverse effects and aberrant behavior; and to discontinue opioid treatment if there is no documented evidence of overall improvement or if there is evidence of illegal activity or drug abuse or adverse effect with the opioid medication. It is not clear from the records how long the injured worker has been on this medication, but the available information indicates it has been denied since 01/2015. The requested dose is the highest dose recommended by the MTUS and it is recommended to be used after several days of step-wise incremental dose of Tramadol. Therefore, if the injured worker is going to use this medication as a first time, the dose is too much as an initial dose. If the injured

worker has been using this medication before this request, the records do not indicate adequate monitoring of pain control, activities status, adverse effects and aberrant behavior, therefore not medically necessary.

Compound cream Ketoprofen 10% base 300gms with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter (Online Version).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 98-99.

Decision rationale: The injured worker sustained a work related injury on 7/14/14. The medical records provided indicate the diagnosis of thoracic sprain-strain, cervical sprain-strain, contusion of elbow, lumbar spine strain. Treatments have included medication, physical therapy, chiropractic care, activity modification, and transcutaneous electrical nerve stimulation (TENS) unit with therapy. The medical records provided for review do not indicate a medical necessity for Compound cream Ketoprofen 10% base 300gms with 3 refills. Ketoprofen cream is a topical analgesic. The topical analgesics are largely experimental drugs primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The MTUS does not recommend any compounded product that contains at least one drug (or drug class) that is not recommended. Ketoprofen is not currently FDA approved for a topical application, therefore not medically necessary.