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| Case Number: | CM15-0163881 | | |
| Date Assigned: | 09/01/2015 | Date of Injury: | 10/05/2010 |
| Decision Date: | 10/16/2015 | UR Denial Date: | 08/18/2015 |
| Priority: | Standard | Application Received: | 08/20/2015 |

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: New York

Certification(s)/Specialty: Internal 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:

The injured worker is a 65 year old female, who sustained an industrial injury on 10-5-10. The injured worker was diagnosed as having displacement of lumbar intervertebral disc without myelopathy and degeneration of lumbosacral intervertebral disc. Treatment to date has included lumbar epidural steroid injection, oral medications including Tramadol a 50mg, Omeprazole 20mg and Voltaren 100mg; topical Terocin patch and Flector patch; activity modifications and home exercise program. Currently on 8-3-15, the injured worker complains of low back pain with radiation down right leg, associated with numbness in the feet and weakness in the legs; the pain is constant and moderate in intensity. The pain is described as shooting, cutting, burning and weakness and rated 4 out of 10 with medications and 8 out of 10 without medications. Disability status is noted to be permanent and stationary. Physical exam performed on 8-3-15 revealed restricted range of motion of lumbar spine with tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with spasms and tenderness of sciatic notch and gluteal spasm on the right. The treatment plan included Voltaren 100mg #30, Tramadol 50mg #30, Omeprazole 20mg #60, Terocin patch 2 boxes and Flector patch #8 boxes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro DOS: 8.3.15 Tramadol (Ultram) 50mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids for chronic pain.

Decision rationale: The medication requested for this patient is Tramadol. According to the California MTUS, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain, with any opioid, requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. According to the medical documentation there has been no indication of the medication's pain relief effectiveness and no clear documentation that the patient has responded to ongoing opioid therapy. Per California MTUS Guidelines, there have to be certain criteria followed, including an ongoing review and documentation of pain relief and functional status. There is no clear documentation that meets these guidelines. Medical necessity for the requested medication has not been established. The requested treatment is not medically necessary.

Tramadol (Ultram) 50mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids for chronic pain.

Decision rationale: According to the California MTUS, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per California MTUS Guidelines, treatment of chronic pain, with any opioid, requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. According to the submitted documentation, there has been no indication of the medication's pain relief effectiveness and no clear documentation that the patient has responded to ongoing opioid therapy. Medical necessity for the requested medication has not been established. The requested treatment: Tramadol (Ultram) 50mg #120 is not medically necessary.

Terocin patch: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: There is no documentation provided necessitating the use of the requested topical medication, Terocin. According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating Terocin. This medication contains methyl salicylate, capsaicin, menthol, and lidocaine. MTUS states that capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Methyl salicylate is recommended by CA MTUS. Menthol is not discussed in MTUS and lidocaine is recommended for localized peripheral pain after a trial of first line therapy. Topical lidocaine in the formulation of a dermal patch is the only approved formulation of lidocaine. There is no documentation of intolerance to other previous medications. Medical necessity for the requested topical medication has not been established. The requested treatment: Terocin patch is not medically necessary.

Flector (Diclofenac 1.3%) patches #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to California MTUS Guidelines, NSAIDs (non-steroidal anti-inflammatory drugs) are recommended for acute pain, acute low back pain (LBP), short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. According to ODG, the use of a Flector patch (Diclofenac) is recommended for osteoarthritis after failure of an oral NSAID or contraindications to oral NSAIDs. Physicians should measure transaminases periodically in patients receiving long-term therapy with Diclofenac. This medication may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. In addition, there is no data that substantiate Flector efficacy beyond two weeks. There is little evidence that supports the medication use in the treatment of chronic low back pain. There is no documentation of failed trials of oral NSAIDs, anti-depressants or anti-convulsants. Medical necessity for the requested Flector patch has not been established. The requested treatment: Flector (Diclofenac 1.3%) patches #30 is not medically necessary.