

Case Number:	CM15-0165194		
Date Assigned:	09/10/2015	Date of Injury:	10/14/2014
Decision Date:	10/13/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	08/21/2015

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: California
Certification(s)/Specialty: Family Practice

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 56 year old male, who sustained an industrial injury on 10-14-14. The injured working is on temporarily totally disability. The injured worker is undergoing treatment for cervicgia, cervical and lumbar disc protrusion and radiculopathy, cervical spondylosis, lumbago, lumbar facet dysfunction, sacroiliac joint dysfunction, shoulder pain and anxiety. Medical records dated 6-9-15 indicate the injured worker complains of neck and low back pain. He reports the neck pain radiates shoulders and arms and low back pain radiates to the legs. There is a pending request for epidural steroid injection and he reports he has not received his medication. Physical exam notes lumbar tenderness to palpation, facet loading on the left and positive Spurling's test. Treatment and diagnostics to date has included magnetic resonance imaging (MRI) revealing cervical disc protrusion, back brace, Tramadol, omeprazole, Tizanidine and compound cream containing Lidocaine and Ketoprofen. The original utilization review dated 8-14-15 indicates the request for Tramadol #90, Tizanidine #60 and compound analgesic cream containing Ketoprofen 10 percent and Lidocaine 10 percent is non-certified noting non FDA approval of Ketoprofen, prior modification of Tramadol for weaning and lack of indication of muscle spasm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Compound Analgesic Cream Containing Ketoprofen 10 Percent and Lidocaine 10 Percent: 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 the MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines state that there is little to no research to support the use of many these agents. Specifically, the MTUS guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The MTUS guidelines state that Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. In addition, topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The request for Retro Compound Analgesic Cream Containing Ketoprofen 10 Percent and Lidocaine 10 Percent is not medically necessary or appropriate.

Retro Tramadol 50 MG #90: 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, criteria for use, Opioids for chronic pain, Opioids, specific drug list.

Decision rationale: The long term use of opioids is not supported per the MTUS guidelines due to the development of habituation and tolerance. As noted in the MTUS guidelines, "A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. (Eriksen, 2006)" In addition, despite the ongoing utilization of Tramadol, the medical records do not establish subjective or objective functional improvement. There is no change in work status. Per the MTUS guidelines, in order to support continued opioid use, there should be improvement in pain and function. The request for Tramadol is therefore not supported. The request for Retro Tramadol 50 MG #90 is not medically necessary or appropriate.

Retro Tizanidine 2 MG #60: 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): Muscle relaxants (for pain).

Decision rationale: The MTUS guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. The MTUS guidelines state that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. The guidelines note that efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The medical records indicate that the injured worker has been prescribed muscle relaxants for an extended period of time. Chronic use of muscle relaxants is not supported and as such the request for Retro Tizanidine 2 MG #60 is not medically necessary or appropriate.