

Case Number:	CM15-0205144		
Date Assigned:	10/22/2015	Date of Injury:	08/16/2013
Decision Date:	12/28/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	10/19/2015

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: 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:

The injured worker is a 42 year old male, who sustained an industrial injury on 8-16-15. The injured worker is diagnosed with compression fracture, discogenic back pain, foraminal narrowing and radiculopathy. His work status is temporary total disability; disability status is permanent and stationary. Notes dated 8-13-15 and 8-24-15 reveals the injured worker presented with complaints of intermitted low back pain and stiffness that radiates into his legs bilaterally. The pain is increased with standing, walking, bending, stooping and lifting greater than 15-20 pounds. He reports his upper and mid back pain is 50% improved. Physical examinations dated 6-1-15 and 8-24-15 revealed decreased lumbar spine range of motion, lumbar midline and paraspinal tenderness, abnormal heel-to walk due to pain and straight leg raise causes back pain. Treatment to date has included acupuncture, which provides some relief per note dated 8-24-15, medications; (9-2015) Relafen, Prilosec, Flurbiprofen 20%-Lidocaine 5% cream, Lidocaine 6%-Gabapentin 10%-Ketoprofen 10% cream, physical therapy, back brace and corset, lumbar epidural steroid injections relieved pain for 3 months per note dated 8-13-15 and physical therapy. Diagnostic studies include electrodiagnostic studies, lumbar and thoracic MRI, x-rays and urine toxicology screen. A request for authorization dated 9-11-15 for Relafen 500 mg #60 with 4 refills, Prilosec 20 mg #60 with 4 refills, Flurbiprofen 20%-Lidocaine 5% cream 240 grams and Lidocaine 6%-Gabapentin 10%-Ketoprofen 10% cream 240 grams is denied, per Utilization Review letter dated 9-17-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Relafen 500 mg Qty 60 with 4 refills, 2 times daily as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The medical record contains no documentation of functional improvement. Guidelines recommend NSAIDs as an option for short-term symptomatic relief. Relafen 500 mg Qty 60 with 4 refills, 2 times daily as needed is not medically necessary.

Prilosec 20 mg Qty 60 with 4 refills, 2 times daily: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Prilosec 20 mg Qty 60 with 4 refills, 2 times daily is not medically necessary.

Topical cream: Flurbiprofen 20%, Lidocaine 5%, 240 gram jar: Upheld

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

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

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen topical is not supported by the MTUS. Topical cream: Flurbiprofen 20%, Lidocaine 5%, 240 gram jar is not medically necessary.

Topical cream: Lidocaine 6%, Gabapentin 10%, Ketoprofen 10%, 240 gram jar: Upheld

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

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

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Ketoprofen agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Topical cream: Lidocaine 6%, Gabapentin 10%, Ketoprofen 10%, 240 gram jar is not medically necessary.