

Case Number:	CM15-0040873		
Date Assigned:	03/11/2015	Date of Injury:	06/21/2007
Decision Date:	04/21/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	03/03/2015

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: Physical Medicine & Rehabilitation

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 55-year-old male, who sustained an industrial injury on 6/12/2007. The diagnoses have included status post lumbar fusion, status post anterior cervical discectomy and fusion (ACDF), right rhomboideous trigger point myospasms and tarsal tunnel syndrome. Treatment to date has included physical therapy. According to the progress report dated 7/28/2014, the injured worker complained of cervical spine pain rated with an average intensity of 6-7/10. The injured worker reported the pain to be frequent and to be worse than at the last visit. He complained of lumbar spine pain with an average intensity of 5-6/10. The pain was described as burning. The treatment plan was for additional physical therapy. Medications ordered included Theramine, Gabapentin and Tramadol. Urinalysis toxicology was performed at the visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Gabapentin/Ketoprofen/Lidocaine 6%/20%/6.15% cream #180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111-113.

Decision rationale: The patient presents with pain and weakness in his neck, lower back and upper extremity. The request is for RETRO GABAPENTIN/ KETOPROFEN/ LIDOCAINE 6%, 20%, 6-15% CREAM 180GM. Per 07/28/14 progress report, Theramine, Gabapentin and Tramadol are prescribed. Regarding the patient's work status, the treater simply states that the patient is currently TTD. MTUS guidelines page 111 do not support compounded topical products if one of the compounds are not recommended. MTUS page 111 -113 does not recommend gabapentin as topical cream. MTUS guidelines page 112, on topical lidocaine, do not allow any other formulation of Lidocaine other than in patch form. Therefore, the request IS NOT medically necessary.

Retro Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: The patient presents with pain and weakness in his neck, lower back and upper extremity. The request is for RETRO OMEPRAZOLE 20MG #60. MTUS guidelines page 69 recommends prophylactic use of PPI's when appropriate GI assessments have been provided. The patient must be determined to be at risk for GI events, such as age > 65 years, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID e.g., NSAID + low-dose ASA. In this case, none of the reports mention medications except Theramine, Gabapentin and Tramadol were prescribed on 07/28/14. The treater does not provide appropriate GI assessment to determine whether or not the patient would require prophylactic use of PPI. There is no documentation of any GI problems such as GERD or gastritis to warrant the use of PPI either. None of the reports indicate the patient is even on oral NSAIDs. The request IS NOT medically necessary.

Retro Prednisone 20mg #28: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Oral corticosteroids.

Decision rationale: The patient presents with pain and weakness in his neck, lower back and upper extremity. The patient is s/p C5-6 and C6-7 fusion on 05/20/14. The request is for RETRO PREDNISONE 20MG #28. Per 06/25/14 progress report, "the patient's radicular symptoms have significantly improved since the surgery." Regarding Oral corticosteroids, ODG states "Not recommended for chronic pain. There is no data on the efficacy and safety of systemic

corticosteroids in chronic pain, so given their serious adverse effects, they should be avoided. (Tarner, 2012) See the Low Back Chapter, where they are recommended in limited circumstances for acute radicular pain. Multiple severe adverse effects have been associated with systemic steroid use, and this is more likely to occur after long-term use. And Medrol (methylprednisolone) tablets are not approved for pain (FDA, 2013)." In this case, the patient does not present with an "acute radicular pain" to warrant the use of this medication. Therefore, the request IS NOT medically necessary.