

Case Number:	CM15-0043013		
Date Assigned:	03/13/2015	Date of Injury:	04/30/2001
Decision Date:	05/22/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	03/06/2015

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: Pediatrics, 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 58 year old female, who sustained an industrial injury on 04/30/2001. On provider visit dated 02/02/2015 the injured worker has reported low back and leg pain, and neck and arm pain. On examination she was noted to have tenderness to cervical spine and palpable trigger points are noted in the muscles of the head and neck with a slightly decreased range of motion with in all directions due to pain, tightness and stiffness. Lumbar spine was noted to have bilateral pain at L3-S1 with tenderness to palpation of bilateral sacroiliac joint areas and a decreased range of motion. The diagnoses have included thoracic/lumbosacral neuritis/radiculitis, lumbago, cervicgia, unspecified back disorder, degenerative lumbar/lumbosacral intervertebral disc, myalgia and myositis, unspecified disc disorder cervical region and unspecific disc disorder thoracic region. Treatment to date has included medication, trigger point injections, and MRI scan.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown Prescription of Flur/Gaba/Lido Rub: Upheld

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

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

Decision rationale: Topical NSAID's are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended per MTUS guidelines. Flurbiprofen is not FDA approved for topical use. Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. However, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. This request is not medically necessary and appropriate.

Unknown Prescription of Trama/Baclo Rub: Upheld

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

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

Decision rationale: Per MTUS guidelines Baclofen is not recommended for topical use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Tramadol is not FDA approved for topical use. This request is not medically necessary and appropriate.

Norco 10/325 MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiods, criteria for use 4) On-Going Management Page(s): 78.

Decision rationale: The IW has been on long term opioids which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and reasonable at this time.

Xanax .5 MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: According to MTUS guidelines benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. According to the progress notes the IW has been using benzodiazepines for a prolonged time. This request is not medically necessary and appropriate.