

Case Number:	CM14-0127024		
Date Assigned:	09/10/2014	Date of Injury:	04/08/2013
Decision Date:	10/10/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/11/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 38-year-old female, who reported an injury on 04/08/2013. The mechanism of injury was not provided. On 02/21/2014, the injured worker presented with complaints of lumbar spine pain, which radiated down the bilateral leg extending to the mid thigh region, with numbness and tingling in the pelvic region. Upon examination of the lumbar spine, there was tenderness upon palpation diffusely and hypertonicity. There was a positive straight leg raise to the left and normal reflexes bilaterally. There was decreased sensation on the left at L4 and L5 distribution. MRI of the lumbar spine revealed 3 to 4 mm bulges at the L3-4 and L4-5, causing some mild foraminal narrowing. The diagnoses were lumbar disc herniation at 3 to 4 mm at L3-4 and L4-5. Current medications included tramadol. Provider recommended flurbiprofen/tramadol/ranitidine cream, Kera Tek Gel, Ultram, and Prilosec. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen/Tramadol/Ranitidine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

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

Decision rationale: California MTUS Guidelines states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. There is a lack of documented evidence to indicate that the patient has failed a previous trial with antidepressants and anticonvulsants. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines note that topical NSAIDs are recommended for osteoarthritis and tendinitis of joints amenable to topical treatment. Many agents are compounded as monotherapy or in combination for pain control, including NSAIDs, opioids, capsaicin, local anesthetics, and antidepressants. There is little to no research to support the use of many of these agents. Additionally, the provider does not indicate the dose, quantity, or frequency and the site that is indicated in the request as submitted. As such, medical necessity has not been established. Therefore, the request for Flurbiprofen/Tramadol/Ranitidine is not medically necessary.

Kera Tek Gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 105. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 7th ed. (web), 2009 Salicylate topicals

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 78.

Decision rationale: California MTUS Guidelines states that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Many agents are compounded as monotherapy or in combination for pain control, including NSAIDs, opioids, capsaicin, local anesthetics, and antidepressants. There is little to no research to support the use of many of these agents. Additionally, the provider does not indicate the site at which the gel is indicated for or the frequency of the medication in the request as submitted. As such, medical necessity has not been established. Therefore the request for Kera Tek Gel is not medically necessary.

4. Prilosec 20 Mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 69.

Decision rationale: According to California MTUS, Prilosec may be recommended for injured workers with dyspepsia secondary to NSAID therapy and for those taking NSAID medications who are moderate to high risk for gastrointestinal events. There is lack of documentation that the injured worker had a diagnosis congruent with the guideline recommendation for Prilosec. Additionally, the frequency of the medication was not provided in the request as submitted. As such, medical necessity has not been established. Therefore the request for four Prilosec 20 Mg #60 is not medically necessary.