MAXIMUS Federal Services

Case Number:	CM14-0129453		
Date Assigned:	08/18/2014	Date of Injury:	11/25/2002
Decision Date:	10/08/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	08/14/2014

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 Anesthesiology and Pain Medicine, and is licensed to practice in Florida. 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 55-year-old female who reported an injury after being hit by a heavy object rolling down a ramp on 11/25/2002. On 07/17/2014, her diagnoses included cervical radiculopathy, cervical facetal hypertrophy, chronic cervical strain, chronic lumbar strain, status post lumbar fusion, and lumbar radiculopathy. Her complaints included: dull neck pain radiating to both elbows occurring 90% of the time, which interfered with her ability to bend or twist at the neck; aching upper back pain which was non-radiating occurring 100% of the time which interfered with her ability to bend at the waist or reach above her shoulders; left hip pain which was sharp and radiating to her left knee occurring 100% of the time and interfered with her ability to lay down, sit, stand or twist at the waist; left foot/ankle pain which was sharp and nonradiating occurring 100% of the time and interfered with her ability to walk; and stabbing lower back pain radiating to the left knee occurring 100% of the time which interfered with her ability to bend, lie down, sit, stand, and walk. This injured worker had been prescribed Hydrocodone 10 mg and Soma of an unknown dose, however, repeated drug screen were negative for those 2 medications. Because of the problems with her urine screens, she was being started on Tramadol 50 mg and Orphenadrine 100 mg instead of the Soma plus an anti-inflammatory NSAID cream. There was no Request for Authorization included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Medications 07/17/14; Tramadol 50mg X 180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The request for retrospective medications 07/17/14; Tramadol 50mg x 180 is not medically necessary. The California MTUS Guidelines recommend ongoing review of opioid use including documentation of pain relief, functional status, appropriate medication use, and side effects. Regarding appropriate use, opioids should be discontinued if it had been determined that the patient has not had treatment failure due to causes that can be corrected, such as under dosing or inappropriate dosing schedule. The criteria for immediate discontinuation of opioids includes when serious non-adherence is occurring. Since the documentation submitted attests that this injured worker's urine drug screens had not shown the presence of opioid metabolites on a number of occasions, this is cause for immediate discontinue of opioids, which includes Tramadol. The clinical information submitted failed to meet the evidence based guidelines for continued opioid use. Additionally, there was no frequency included with the request. Therefore, this request for retrospective medications 07/17/14; Tramadol 50mg x 180 is not medically necessary.

Retro Medications 07/17/14;Orphenadrine Citrate 100mg X 180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: The request for retrospective medications 07/17/14; Orphenadrine Citrate 100mg x 180 is not medically necessary. The California MTUS Guidelines recommend that muscle relaxants be used with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lower back pain. In most low back pain cases, they show no benefit beyond NSAIDs. Orphenadrine Citrate is indicated as an adjunct to rest, physical therapy, and other measure for the relief of discomfort associated with acute musculoskeletal conditions. This drug is similar to diphenhydramine, but has greater anticholinergic effects. The anticholinergic effects include drowsiness, urinary retention, and dry mouth. This submitted documentation attested to this injured workers noncompliance with the previously prescribed Soma. There was no documentation of significant functional benefit with the use of any muscle relaxants. There was no indication that this injured worker would be any more compliant with a different medication. The need for a muscle relaxant was not clearly demonstrated in the submitted documentation. Additionally, the request did not include frequency of administration. Therefore, this request for retrospective medications 07/17/14; Orphenadrine Citrate 100mg x 180 is not medically necessary.

Retro Medications 07/17/14; Flurbiprofen Powder 6gm: 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 Analgesics Page(s): 111-113.

Decision rationale: The request for retrospective medications 07/17/14; Flurbiprofen powder 6gm is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded including NSAIDs for pain relief. There is little to no research to support many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. The only FDA approved NSAID for topical application is Voltaren gel 1% (Diclofenac), which is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. Additionally, the body part or parts to which this powder was to have been applied was not specified in the request, nor was frequency of application. Therefore, this request for retrospective medications 07/17/14; Flurbiprofen powder 6gm is not medically necessary.