

Case Number:	CM14-0140240		
Date Assigned:	09/10/2014	Date of Injury:	03/19/2005
Decision Date:	10/14/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	08/29/2014

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 and Rehabilitation and Pain Medicine and is licensed to practice in California. 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 63-year-old male who reported an injury on 03/19/2005. The mechanism of injury was not submitted for review. The injured worker has diagnoses of cervical spondylosis and lumbar myofascial pain. Past medical treatment consists of surgery, chiropractic therapy, physical therapy, and medication therapy. Medications included Ultram and topical analgesics. There were no urinalyses or drug screens submitted for review. On 08/22/2014, the injured worker complained of back pain. The physical examination of the cervical spine revealed that there was tenderness in the posterior cervical and bilateral trapezial musculature. Forward flexion was within 1 fingerbreadth of the chin to chest, extension was 10 degrees, and lateral rotation was 60 degrees bilaterally. The examination of the lumbar spine revealed that there was tenderness in the lower lumbar paravertebral musculature. Forward flexion was 45 degrees, extension was 10 degrees, and lateral bending was 30 degrees. The treatment plan is for the injured worker to continue the use of medication. The injured worker was also advised to continue the use of a TENS unit. The rationale and Request for Authorization Form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (for chronic pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Ongoing management Page(s): 82, 93, 94, 113, 78.

Decision rationale: The request for Ultram 50 mg #60 with 2 refills is not medically necessary. The California MTUS states central analgesic drugs such as Ultram are reported to be effective in managing neuropathic pain, and it is not recommended as a first line oral analgesic. The California MTUS recommends that there should be documentation of the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. The guidelines also recommend that there should be assessment of pain levels before, during, and after medication. The submitted documentation failed to indicate the efficacy of the medication. Additionally, there was no mention of adverse side effects, activities of daily living, or analgesia. Furthermore, the submitted documentation did not indicate any drug screens or urinalyses showing that the injured worker was in compliance with their prescription medications. Additionally, the submitted documentation did not show what pain levels were before, during, and after the medication. The request as submitted did not indicate the frequency of the medication. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

LF 520 (Lidocaine 5%, Flurbiprofen 20%) 120 grams with 2 refills: 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 request for LF 520 (Lidocaine 5%, Flurbiprofen 20%) 120 grams with 2 refills is not medically necessary. The California MTUS Guidelines state that topical compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety, and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Additionally, any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines state that Lidoderm patch is the only topical form of Lidocaine approved. The included medical documentation did not indicate that the injured worker had not responded to, or was intolerant to, any other treatments. The guidelines do not recommend topical lidocaine in any other form other than Lidoderm. Additionally, the included documentation lacked evidence of the injured worker having trialed and failed any antidepressants or anticonvulsants. Furthermore, the request as submitted did not indicate a frequency or duration of the medication or the site at which the cream would be intended for. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.