

Case Number:	CM14-0216141		
Date Assigned:	01/06/2015	Date of Injury:	04/06/2009
Decision Date:	02/28/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/24/2014

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. 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 patient is a 50 year old female with an injury date of 04/06/09. The 10/24/14 report states the patient presents with upper back pain radiating to the bilateral upper extremities and lower back pain radiating to the bilateral lower extremities right greater than left with muscle spasms. Pain is rated 7/10 with medications and 8/10 without. Her gait is mildly antalgic. She uses a cane for ambulation and a lumbar corset for support. The patient is not working. Examination reveals restricted range of motion of the lumbar spine in all planes and tenderness to palpation of the paraspinal muscles with spasms. There is decreased sensation throughout the lower extremities. The patient's diagnoses include: 1. S/p microlumbar decompression right L5-S1 05/30/13. 2. Lumbar radiculopathy. 3. Facet arthritis of right L4-5 facet joints. 4. Lumbar spondylosis. 5. Lumbar degenerative disease. The patient has been authorized aqua therapy. Medications include Norco, Flexeril, OTC Prilosec, and Gabapentin. There is some GI upset due to medications and authorization for a GI specialist is pending. She is receiving pain psychology treatment. The utilization review is dated 12/03/14. Reports were provided for review from 07/03/14 to 10/24/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol/Acetaminophen 37.5/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opioids, medication for chronic pain Page(s): 88-89, 76-78, 60-61.

Decision rationale: The patient presents with upper back pain radiating to the bilateral upper extremities and lower back pain radiating to the bilateral lower extremities with muscle spasms. The current request is for prospective usage of Tramadol/Apap 37.5/325 mg #90 (an opioid analgesic). The RFA is not included. Tramadol is only listed in the most recent progress report provided dated 10/24/14. The 12/03/14 utilization review modified this request from #90 to #60 to allow for downward titration or discontinuation of the medication. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The reports provided show the patient has been prescribed an opioid, Norco/Hydrocodone, since at least 07/03/14. The 10/24/14 report states that pain medications including Norco, Gabapentin and Flexeril decrease the patient pain from 8/10 to 7/10. Recent reports from 08/28/14 to 09/26/14 show reduction in pain to 7-8/10 with medications and 8-10/10 without. The 08/28/14 report states pain is reduced for approximately 40 minutes by medications. The 09/04/14 report states the patient can stand sit and walk for 30 minutes; however, no specific ADLs are mentioned to show a significant change with use of this medication. Opiate management issues not are sufficiently addressed. The reports do show that CURES was checked on 03/18/14 and 08/28/14 and that information was consistent. Side effects and adverse behavior are documented. However, no UDS's are provided for review or discussed. In this case, there is not sufficient documentation of ADLs and opiate management to support long-term opioid use. The request is not medically necessary.

CM3 Ketoprofen 20% cream #1: 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): 111-112.

Decision rationale: The patient presents with upper back pain radiating to the bilateral upper extremities and lower back pain radiating to the bilateral lower extremities with muscle spasms. The current request is for: prospective usage of CM3 Ketoprofen 20% cream #1 per the 10/24/14 report. MTUS Topical Analgesics guidelines pages 111 and 112 has the following regarding topical creams, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS further states, "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of

photocontact dermatitis." The reports provided show the treater is starting this medication as a trial on 10/24/14 in an attempt to limit oral medications. In this case, the requested topical cream contains Ketoprofen which is not FDA approved for topical application. Lacking recommendation by MTUS, the request is not medically necessary.