

Case Number:	CM15-0010837		
Date Assigned:	01/28/2015	Date of Injury:	10/18/1998
Decision Date:	03/26/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/20/2015

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: Anesthesiology

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 50 year old sustained an industrial injury on 10/18/98, with subsequent ongoing low back pain. Current diagnoses included lumbar discopathy with disc displacement status post lumbar fusion, lumbar radiculopathy and right sacroiliac arthropathy. In a PR-2 dated 1/5/15, the injured worker complained of residual pain over the right sacroiliac joint with radiation down in the right buttocks associated with cramping in the right calf muscle. Physical exam was remarkable for tenderness to palpation over the lumbar paraspinal musculature and right sacroiliac joint with positive Fabere and Patrick's maneuver, loss of normal lumbar lordosis, decreased range of motion secondary to pain and stiffness and positive straight leg raise in the right lower extremity. Motor strength was 5/5 in bilateral upper and lower extremities. Sensory exam was diminished to light touch and pinprick in the right S1 dermatomal distribution. Reflexes were 1+ throughout. The treatment plan included continuing medications (Prilosec, Norco 10/325, Ultram, Nalfon and compound cream), obtain a urine toxicology screen and repeat request for authorization for computed tomography lumbar spine to assess the degree of fusion and assess the right sacroiliac joint for spondylolysis. On 12/22/14, Utilization Review non-certified a request for Nalfon 400 mg, ninety count, Prilosec (Omeprazole DR) 20 mg, ninety count, Cyclobenzaprine 10%/Tramadol 10% 15 grams and 60 grams topical cream, Urine toxicology testing in sixty to ninety days and computed tomography scan of the lumbar spine. Utilization Review modified a request for Ultram ER 150 mg, ninety count to Ultram ER 150 mg, thirty count. Utilization Review cited CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram ER 150 mg, ninety count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-96. Decision based on Non-MTUS Citation Pain

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness and no clear documentation that the patient has responded to ongoing opioid therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to discontinue, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Nalfon 400 mg, ninety count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS (2009), Anti-inflammatory Medications, NSAIDs Page(s): 21, 67-71. Decision based on Non-MTUS Citation NSAIDs

Decision rationale: Fenoprofen calcium (Nalfon) is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. According to the California MTUS Guidelines, NSAIDs reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain. Current evidence-based guidelines indicate that Fenoprofen is an NSAID medication which is less effective, and has greater side effects than Naproxen or Ibuprofen. Guidelines indicate that Fenoprofen should not be used unless there is a sound medical basis for not using a safer or more effective alternative NSAID. In this case, the patient has chronic pain from an injury sustained in 1998 and long-term use of NSAIDs is not

recommended. The medical records do not clearly establish when this medication was started or the duration of treatment, or any functional benefit obtained from the use of Fenoprofen. Medical necessity for continued use has not been established. The requested medication is not medically necessary.

Cyclobenzaprine 10%/Tramadol 10% 15 grams and 60 grams topical cream: 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: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, muscle relaxants, local anesthetics or antidepressants. In this case, the topical compound is Cyclobenzaprine 10%/Tramadol 10%. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. According to evidence-based guidelines, this particular specific formulation contains agents that are not recommended for topical use, specifically Cyclobenzaprine. There is also no indication that the topical form of Tramadol is efficacious. Medical necessity of the topical analgesic has not been established. The requested medication is not medically necessary.

Prilosec (Omeprazole DR) 20 mg, ninety count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS, PPIs Page(s): 68. Decision based on Non-MTUS Citation PPIs

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. In this case, there is no documentation indicating that this patient had any GI symptoms or risk factors. Therapy with a PPI is not medically necessary for this patient. Medical necessity for Omeprazole has not been established. The requested medication is not medically necessary.

Urine toxicology testing in sixty to ninety days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS (2009), Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Urine Drug Testing

Decision rationale: According to CA MTUS (2009), a urine drug screen is recommended as an option to assess for the use or the presence of illegal drugs. According to ODG, urine drug testing (UDT) is a recommended tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. In this case, the treating physician does not specify when the last urine toxicology screening was performed. There is no documentation that the patient is indicated to be anything other than a low risk to require testing more than once or twice per year. Therefore, the request for Urine toxicology testing in 60-90 days is not indicated. Medical necessity of the requested service has not been established. The requested urine test is not medically necessary.

CT scan of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: According to ACOEM, a computed tomography (CT) scan of the lumbar spine in patients with previous lumbar fusion is indicated IF plain films do not confirm a successful fusion. In this case, the provider requested a CT scan of the lumbar spine to assess the lumbar fusion. According to the medical records, a CT scan of the lumbar spine was obtained on 10/18/13, which demonstrated a lumbar fusion with interbody grafts at L4-5 and L5-S1. There is no documentation indicating the plain films were recently done and therefore, no specific indication from the provider on why another CT scan was necessary. Medical necessity for the requested CT scan of the lumbar spine has not been established. The requested CT scan is not medically necessary.