

Case Number:	CM15-0116766		
Date Assigned:	06/24/2015	Date of Injury:	10/01/2012
Decision Date:	07/28/2015	UR Denial Date:	06/01/2015
Priority:	Standard	Application Received:	06/16/2015

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: 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 injured worker is a 52-year-old male who sustained a work related injury October 1, 2012. He fell from second story-collapsed scaffolding, onto his feet, and then fell to his left knee. He was initially treated with medication and a lumbar brace, and an MRI of the lumbar spine was performed. According to a primary treating physician's follow-up consultation, dated May 6, 2015, the injured worker presented with low back pain with increasing left greater than right, lower extremity symptoms, 7/10. He also reports instability and near falls, testicular pain, and intermittent urinary incontinence over the past 6 weeks. Objective findings included lumbar range of motion; flexion 50 degrees, extension 40 degrees, left and right lateral tilt 40 degrees. There is a positive straight leg raise left, for pain to the foot and right for pain to the distal calf. Diagnoses are protrusion 4 mm L3-4 and 6 mm, right greater than left L4-5; s/p remote lumbar decompression, L4-5; reactive depression. Treatment plan included a yet to proceed with epidural injection left L3-4 and L4-5, neurologist and psychology consultations; continued use of TEN's unit, continue use of lumbar brace, and at issue, the request for authorization for Ketoprofen cream and Hydrocodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 300g cream w/ 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Based on the 05/06/15 progress report provided by treating physician, the patient presents with low back pain rated 7/10 with left greater than right lower extremity symptoms. The patient is status post remote lumbar decompression L4-5, date unspecified. The request is for KETOPROFEN 300G CREAMS W/ 3 REFILLS. RFA with the request not provided. Patient's diagnosis on 05/06/15 includes protrusion 4mm at L3-4 and 6mm, right greater than left L4-5 and reactive depression. Physical examination to the lumbar spine on 05/06/15 revealed normal range of motion and positive straight leg raise test bilaterally. Treatment to date included imaging studies, trigger point injections, lumbar brace, TENS, activity modifications and medications. Patient's medications include Hydrocodone and Xanax. The patient is temporarily totally disabled, per 05/06/15 report. Treatment reports were provided from 01/16/15 -06/03/15. 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 photo contact dermatitis." Per 05/06/15 progress report, treater states "Recall successful trial as this did facilitate up to 5 point diminution in pain and improve range of motion." However, the requested topical compound contains Ketoprofen, which is not currently FDA approved for topical application, per MTUS. MTUS page 111 states that if one of the compounded topical products is not recommended, then the entire product is not. This request does not meet guideline criteria. Therefore, the request IS NOT medically necessary.

Hydrocodone 10mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Hydrocodone Page(s): 76-78, 88-90, 80-81.

Decision rationale: Based on the 05/06/15 progress report provided by treating physician, the patient presents with low back pain rated 7/10 with left greater than right lower extremity symptoms. The patient is status post remote lumbar decompression L4-5, date unspecified. The request is for HYDROCODONE 10MG. RFA with the request not provided. Patient's diagnosis on 05/06/15 includes protrusion 4mm at L3-4 and 6mm, right greater than left L4-5 and reactive depression. Physical examination to the lumbar spine on 05/06/15 revealed normal range of motion and positive straight leg raise test bilaterally. Treatment to date included imaging studies, trigger point injections, lumbar brace, TENS, activity modifications and medications. Patient's medications include Hydrocodone, Tramadol and Xanax. The patient is temporarily totally disabled, per 05/06/15 report. Treatment reports were provided from 01/16/15 -06/03/15. Pages 80, 81 of MTUS also states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." 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. MTUS p77 states, "Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs." Hydrocodone has been included in patient's medications, per progress reports dated 01/16/15, 03/27/15, and 06/03/15. In this case, treater has not stated how Hydrocodone reduces pain and significantly improves patient's activities of daily living with specific examples. MTUS states "function should include social, physical, psychological, daily and work activities." UDS dated 02/27/15 and 04/27/15 showed results consistent with prescriptions, and treater has documented the patient being at high risk for aberrant behavior; but no opioid pain agreement or CURES reports were provided. There are no before and after pain scales or validated instruments addressing analgesia; no return to work, or change in work status, either. MTUS requires appropriate discussion of the 4A's. Furthermore, MTUS does not clearly support chronic opiate use for this kind of condition, chronic low back pain and radiculopathy. Given the lack of documentation as required by guidelines, the request IS NOT medically necessary.