

<b>Case Number:</b>	CM15-0120706		
<b>Date Assigned:</b>	07/01/2015	<b>Date of Injury:</b>	04/07/2014
<b>Decision Date:</b>	08/12/2015	<b>UR Denial Date:</b>	06/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/22/2015

### 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: Connecticut, California, Virginia  
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 37 year old female, who sustained an industrial injury on April 7, 2014, incurring lower extremity injuries. She was diagnosed with a left tibial plateau fracture. She underwent an open reduction internal fixation of the left tibial plateau fracture. Treatment included physical therapy, topical analgesic gel and steroid injections and work restrictions. Currently, the injured worker complained of constant bilateral shoulder pain increased with range of motion, lifting, carrying, pushing and pulling. She complained of persistent left knee pain with swelling, popping and clicking. X rays of the knee revealed lateral joint collapse with surgical hardware intact but within good alignment. She was noted to have significant functional deficits secondary to increased pain. The treatment plan that was requested for authorization included prescriptions for Kera Tek gel, Tramadol and Motrin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kera tek gel (Methyl salicylate/menthol) 4 oz:** 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 MTUS guidelines on Topical Analgesics describe topical treatment as an option however topicals are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The MTUS states specifically that any compound product that contains at least one drug (or class) that is not recommended is not recommended. The lack of evidence to support use of topical compounds like the one requested coupled with the lack of further clinical reasoning for the request makes the requested treatment not medically indicated.

**Ultram (Tramadol 50mg) #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

**Decision rationale:** Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. Utilization Review reasonably recommended weaning to facilitate appropriate discontinuation. Given the lack of clear evidence to support functional improvement on the medication and the chronic risk of continued treatment, the request for Ultram is not considered medically necessary.

**Motrin (Ibuprofen 800mg) #60 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-68.

**Decision rationale:** Utilization of ibuprofen in chronic pain is concerning; when considering use of NSAIDs, and according to the MTUS, it is recommended that the lowest dose for the shortest period be used in patients with moderate to severe pain. Per the MTUS, acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those

with gastrointestinal, cardiovascular, or renovascular risk factors. The main concern for drug selection is based on risk of adverse effects. In this case, utilization review has reasonably non-certified the request for Motrin tablets as there is little evidence of functional improvement on the medication. In this case it appears that the benefit of taking the medication does not outweigh the risk as chronic treatment is not likely to result in an improved clinical picture. Therefore the request is not considered medically necessary at this time.