
Independent Medical Review Final Determination Letter

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Dated: 12/20/2013

IMR Case Number:	CM13-0010110	Date of Injury:	3/12/2003
Claims Number:	██████████	UR Denial Date:	7/26/2013
Priority:	Standard	Application Received:	8/12/2013
Employee Name:	██████████		
Provider Name:	██████████		
Treatment(s) in Dispute Listed on IMR Application:	Please reference utilization review determination letter		

DEAR ██████████

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, ██████████

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

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

This patient is a 54-year-old male with a stated date of injury of 03/12/2003. The documentation submitted for review indicates that the patient has been followed for left upper extremity complaints, medial left elbow pain, left wrist pain, and constant neck, low back pain, and headaches. The patient was evaluated on 05/10/2013 and clinical notes indicated cervical range of motion was decreased with 40 degrees of flexion, 40 degrees extension, right rotation of 70 degrees, left rotation 65 degrees, right lateral flexion of 35 degrees, and left lateral flexion of 35 degrees. Left elbow range of motion was to 120 degrees of flexion and 0 degrees of extension, 70 degrees supination, and 70 degrees pronation. Left wrist range of motion revealed flexion to 50 degrees, extension 50 degrees, radial deviation 20 degrees, and ulnar deviation 30 degrees. Lumbar range of motion revealed flexion of 30 degrees, extension 15 degrees, and right and left lateral flexion 10 degrees. Treatment plan notes indicated the patient was provided with Tramadol/acetaminophen 37.5/325 mg, and given a prescription for gabapentin/L carnitine 250/125 mg, Percocet 10/325 mg #30, Norco 10/325 mg #120, Medrox patches #60, and topical medication consisting of Flurbiprofen 15%, Cyclobenzaprine 10% in a 240 mg tube, and Tramadol 8%, gabapentin 10%, and menthol 2%, camphor 2%, and Capsaicin 0.5% in a 250 mg tube.

IMR DECISION(S) AND RATIONALE(S)

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

1. Tramadol HCL 37.5/325mg is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009) and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 83, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS states weak opioids such as tramadol/Acetaminophen should be considered for short term use after there has been evidence of failure of a first line therapy for osteoarthritis such as acetaminophen or and NSAID. The documentation submitted for review failed to indicate if the patient had been trialed on a first line therapy prior to the prescription of Tramadol HCl/acetaminophen. Given the above, the request for Tramadol HCl 37.5-325 mg is not medically necessary and appropriate.

2. Gabapentin/L-Carnitine 250/125mg is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009) and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 111-113, which are part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS states topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to its support use. Based on the recommendation of the guideline, the request for gabapentin/L carnitine 250/125 mg is not medically necessary and appropriate.

3. Medrox patches #60 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009) and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 111-113, which are part of the MTUS; and the following website: dailymed.nlm.nih.gov, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS states topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. While methyl salicylate may be recommended per the guidelines, Capsaicin in a 0.0375% formulation is not recommended by the guidelines. Therefore, the request for Medrox patches #60 is not medically necessary and appropriate.

4. Tramadol 8%/Gabapentin 10%/Menthol 2%/Camphor 2%/capsaicin 0.5% 240gm is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009) and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 111-113, which are part of the MTUS, and the following article: Effectiveness of topical administration of opioids in palliative care: a systematic review B LeBon, G Zeppetella, IJ Higginson - Journal of pain and symptoms, 2009, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS states topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Clinical literature states there is a deficiency of higher quality evidence on the role of topical opioids and that more robust primary studies are required to inform practice recommendations. Also, Gabapentin is not recommended. There is no peer-reviewed literature to its support use. Given the above, the request for Tramadol 8%/gabapentin 10%/menthol 2%/camphor 2%/Capsaicin 0.5%, 240 g is not medically necessary and appropriate.

5. Norco 10/325mg #120 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009) and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 78 and 91, which are part of the MTUS.

The Physician Reviewer's decision rationale: CA MTUS states Norco is indicated for moderate to moderately severe pain. Also, Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000). There was a lack of documentation submitted for review detailing effective analgesia of Norco, increase in the patient's abilities to undertake activities of daily living with Norco, and a lack of documentation indicating if adverse side effects and aberrant drug related behaviors have been addressed with the patient. Given the above, the request for Norco 10/325 mg #120 is not medically necessary and appropriate.

6. Flurbiprofen 15%/Cyclobenzaprine 10% 240gm is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009) and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS states topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. NSAIDs have little for utilization for topical treatment of osteoarthritis of the spine, hip or shoulder. Also, guidelines indicate that there is no evidence to support the use of any muscle relaxant as a topical product. Based on the recommendation of the guidelines the request for Flurbiprofen 15%/Cyclobenzaprine 10%, 240 g is not medically necessary and appropriate.

7. Urinalysis drug screen is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009) and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 43, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS states that drug screens are recommended as an option, to assess for the use or the presence of illegal drugs and for steps to take before a therapeutic trial of opioids as well as for on-going management for differentiation between dependence & addiction and as a step to avoid misuse /addiction. The documentation submitted for review is insufficient to detail that the patient has undergone assessment indicating the patient's level of risk for aberrant drug taking behavior, which leads to the intervals for urine drug screens. While testing is of course indicated by the guidelines, consideration for at risk behavior should dictate the intervals at which testing is completed and the degree of testing. Also, there is no indication in the notes of prior noncompliant drug screens. Given the above, the request for urinalysis drug screen is not medically necessary and appropriate.

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]

CM13-001110