

Case Number:	CM13-0009243		
Date Assigned:	12/11/2013	Date of Injury:	05/13/2002
Decision Date:	02/17/2014	UR Denial Date:	07/22/2013
Priority:	Standard	Application Received:	08/09/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in Ohio and Texas 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 42-year-old female who reported an injury on 05/13/2002, which ultimately resulted in a failed spinal fusion surgery at the L5-S1 level with subsequent spinal cord stimulator implantation. The patient's chronic pain was managed with epidural steroid injections and multiple medications. The patient's most recent clinical examination findings included tenderness to palpation over the paraspinal musculature with increased pain with range of motion in flexion and extension and a positive straight leg raising test on the left. The patient's medications were listed to be Effexor, Xanax, Norco, Terocin, Neurontin, and Cleocin. The patient's diagnoses included low back pain, post-laminectomy syndrome, lumbar radiculopathy, spinal cord stimulator dysfunction, and chronic pain syndrome. The patient's treatment plan was to continue medication usage.

IMR ISSUES, DECISIONS AND RATIONALES

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

Alprazolam 0.5mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The requested Alprazolam 0.5mg, #60 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration of time. The California Medical Treatment and Utilization Schedule does not recommend the use of benzodiazepines for the long-term treatment of issues related to chronic pain. The clinical documentation submitted for review does not provide any evidence that the patient has had significant functional benefit resulting from this medication. Therefore, continued use would not be supported. As such, the requested Alprazolam 0.5mg, #60 is not medically necessary or appropriate.

Norco 10/325mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78.

Decision rationale: The requested Norco 10/325mg, #120 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that this is a recent medication change. The California Medical Treatment and Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, significant pain relief, management of side effects, and monitoring for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is being monitored for aberrant behavior and has pain relief with medications rated at a 6/10 compared to without medications at a 9/10. However, specific documentation of functional benefit is not provided. Therefore, continued use cannot be supported. As such, the requested Norco 10/325mg, #120 is not medically necessary or appropriate.

Terocin 120ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Medications for Chronic Pain Page(s): 60, 111.

Decision rationale: The requested Terocin 120ml is not medically necessary or appropriate. The patient does have continued pain complaints of the lumbar spine. The requested Terocin cream contains methyl salicylate, capsaicin, menthol, and lidocaine. The California Medical Treatment and Utilization Schedule does recommend the use of methyl salicylate and menthol as topical agents for osteoarthritic related symptoms. However, the use of capsaicin is only recommended for patients who are intolerant or unresponsive to other treatments including oral analgesics. The clinical documentation submitted for review does not provide any evidence that the patient has been unresponsive or intolerant of other treatments. Additionally, the California Medical Treatment and Utilization Schedule states that, "No other commercially approved

topical formulation of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain." As the use of lidocaine in a cream is not supported by the FDA, it would also not be supported by the California Medical Treatment and Utilization Schedule. Additionally, the California Medical Treatment and Utilization Schedule recommends the introduction of pain medications for the management of chronic pain be introduced 1 at a time. Therefore, a formulation of medication with multiple medications would not be indicated. Additionally, any compounded agent with an element that is not recommended is not supported by Guideline recommendations. As such, the requested Terocin 120ml is not medically necessary or appropriate.

Neurontin 300mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and, Antiepilepsy drugs (AEDs) Page(s): 16, 60.

Decision rationale: The requested Neurontin 300mg, #90 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. The California Medical Treatment and Utilization Schedule recommends the continued use of medications for the management of a patient's chronic pain be supported by symptom response and functional benefit. The clinical documentation submitted for review does provide evidence that the patient has pain relief related to the medication schedule that includes gabapentin. This is described as 6/10 with medications and 9/10 without medications. However, there is no specific documentation addressing examples of increased functional benefit relating to this medication. Therefore, continued use would not be supported. As such, the requested Neurontin 300mg, #90 is not medically necessary or appropriate.