

<b>Case Number:</b>	CM13-0011026		
<b>Date Assigned:</b>	03/10/2014	<b>Date of Injury:</b>	01/17/2006
<b>Decision Date:</b>	04/10/2014	<b>UR Denial Date:</b>	08/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/16/2013

### 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. The expert reviewer is Board Certified in Family Practice and is licensed to practice in 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 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/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 37-year-old male who reported an injury on 01/17/2006. The mechanism of injury was not provided for this review. The patient ultimately underwent anterior fusion at the L4-5 and L5-S1. The patient's postsurgical chronic pain was managed with physical therapy and medications. The patient's medication schedule included Ultram, Anaprox, Fexmid, Hydrocodone, and Medrox patches. The patient's most recent clinical evaluation documented that the patient had continued pain. It was documented the patient's treatment history included completion of a weight loss program. Physical findings included restricted range of motion of the lumbar spine with weakness of the left EHL and a positive straight leg raising test with diminished sensation of the left-sided L4, L5, and S1 dermatomes. The patient's diagnoses included a recurrent herniated disc. The patient's treatment plan included continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ULTRAM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram)..

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

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines recommends the continued use of opioids in management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient is monitored for aberrant behavior. Additionally, there is no documentation that the patient has any functional benefit from the medication usage. Also, there is no documentation of a quantitative assessment of pain relief to establish the efficacy of medication usage. The request as it is written does not identify dosage, frequency, or intended duration of treatment. Therefore, the appropriateness of this medication cannot be determined. The request for Ultram is not medically necessary or appropriate.

**FEXMID:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page(s): 63.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines do not recommend the extended use of muscle relaxants in the management of chronic pain. As the patient has been on this medication for an extended duration and there are no exceptional factors noted to support extending treatment beyond guideline recommendations, continued use is not supported. Additionally, the request as it is submitted does not clearly define a dosage, frequency, or intended duration of treatment. The request for Fexmid is not medically necessary and appropriate.

**HYDROCODONE #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone (Vicodin, Lortab)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ON-GOING MANAGEMENT, Page(s): 78.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines recommends the continued use of opioids in management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient is monitored for aberrant behavior. Additionally, there is no documentation that the patient has any functional benefit from the medication usage. Also, there is no documentation of a quantitative assessment of pain relief to establish the efficacy of medication usage. The request as it is written does not identify dosage, frequency, or intended duration of treatment. Therefore, the appropriateness of this medication

cannot be determined. The request for Hydrocodone #60 is not medically necessary and appropriate.

**MEDROX PATCHES:** 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.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines does not recommend the use of Capsaicin as a topical agent unless the patient has failed to respond to other first line therapies. The clinical documentation does not provide any evidence that the patient has failed to respond to anticonvulsants or antidepressants, which are initial first line treatments for chronic pain. Additionally, there is no documentation of functional benefit or pain relief resulting from this medication to support extending treatment beyond guideline recommendations. Also, the request as it is written does not clearly identify a frequency, dosage, or intended duration of treatment. Therefore, the appropriateness of this medication cannot be determined. The request for Medrox Patches are not medically necessary and appropriate.