

Case Number:	CM13-0015653		
Date Assigned:	03/12/2014	Date of Injury:	07/13/2001
Decision Date:	04/23/2014	UR Denial Date:	07/24/2013
Priority:	Standard	Application Received:	08/23/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, 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 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 53-year-old with a date of injury of July 13, 2001. The listed diagnoses per ■■■ dated July 12, 2013 are: (1) Lumbar post laminectomy syndrome, (2) status post L5 to S1 fusion, (3) disk protrusion at L5 measuring 5 mm that impinges on S1 nerve root, (4) right sacroiliac joint pain, (5) right lumbar facet joint pain at L4-L5 and L5-S1, (6) left lumbar facet joint pain at L4-L5 and L5-S1, (7) hypertrophy at bilateral L4-L5 and bilateral L5-S1 facet joints, (8) lumbar facet joint arthropathy, (9) central disk protrusion at L2 to L4 and L5-S1 measuring 2 mm, (10) central disk protrusion at L1-L2, (11) lumbar stenosis, (12) lumbar strain/sprain. According to report dated July 12, 2013 by ■■■, patient presents with bilateral midback and low back pain that radiates into the right bilateral anterolateral thighs. It was noted the patient is status post L5-S1 lumbar ESI (epidural steroid injection) which produced 50% pain relief from low back pain and right lower extremity radicular symptoms. There is no physical examination noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

GYM MEMBERSHIP FOR POOL ACCESS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter, Shoulder Chapter, and Low Back Chapter.

Decision rationale: This patient presents with mid and low back pain. Treater is requesting a gym membership for aquatic therapy. Gym memberships are not specifically addressed in ACOEM. However, the ODG states "it is not recommended as a medical prescription unless a documented home exercise program with periodic assessment or revision have not been effective and there is a need for equipment. Treatment needs to be monitored and administered by medical professionals." While an individual exercise program is recommended, outcomes that are not monitored by a healthcare professional such as gym memberships or advanced home exercise equipment is not recommended and not covered under this guideline. The request for a gym membership for pool access is not medically necessary or appropriate.

PRESCRIPTION OF FENTANYL PATCH 50MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic Section Page(s): 44, 60.

Decision rationale: This patient presents with continued mid and low back pain. Treater is requesting fentanyl patch 50 mcg #10. The Chronic Pain Medical Treatment Guidelines states Duragesic (fentanyl transdermal system) is not recommended as a first line therapy. Duragesic is a trade name of fentanyl transdermal therapeutic system which releases fentanyl, a potent opiate, slowly to the skin. This medication is not supported as a first line therapy. In addition, the Chronic Pain Medical Treatment Guidelines requires documentation of pain assessment and functional changes when medications are used for chronic pain. Medical records indicate that this patient has been prescribed fentanyl patches as early as January 15, 2013. Thorough review of ten progress reports do not show any pain assessment or documentation of functional improvement with this medication. The request for one prescription of Fentanyl patch 50 mg is not medically necessary or appropriate.

PRESCRIPTION OF PERCOCET 10/325MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain, and Criteria for Use of Opioids Page(s): 80-81, 88-89.

Decision rationale: This patient presents with mid and low back pain. Treater is requesting Percocet 10/325 mg #120. For chronic opiate use, the Chronic Pain Medical Treatment Guidelines require functioning documentation using a numerical scale or a validated instrument at least once every 6 months. Documentation of the 4 A's (analgesia, ADLs [activities of daily

living], adverse side effects, adverse behavior) is required. Furthermore, under outcome measure, it also recommends documentation of chronic pain, average pain, least pain, the time it takes for medication to work, duration of pain relief with medication, etc. Medical records indicate that this patient has been prescribed these medications since January 15, 2013. In the ten progress reports provided for review, there is not documentation regarding how Percocet has been helpful in terms of decreased pain or functional improvement. The request for Percocet 10/325 mg, 120 count, is not medically necessary or appropriate.

PRESCRIPTION OF CARISOPRODOL 350MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

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

Decision rationale: This patient presents with continued mid and low back pain. Treater is requesting carisoprodol 350 mg #60. For muscle relaxants, the Chronic Pain Medical Treatment Guidelines states, "Recommended non-sedating muscle relaxants with caution as a second option for short-term treatment of acute exacerbation of patients with chronic lower back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit on NSAIDs (non-steroidal anti-inflammatory drugs) and pain, and overall improvement. Efficacy appears to diminish overtime, and prolonged use of some medications in this class may lead to dependence." In this case, medical records indicate that this patient has been taking this medication since January 15, 2013. Muscle relaxants are not recommended for long-term use by the Chronic Pain Medical Treatment Guidelines. The request for Carisoprodol 350 mg, 60 count, is not medically necessary or appropriate.

PRESCRIPTION OF GABAPENTIN 300MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin and Pregabalin Page(s): 18-19, and 49.

Decision rationale: This patient presents with continued mid and lower back pain. The treater is requesting gabapentin 300 mg #180. Utilization Review dated July 24, 2013 denied request stating no documentation is supporting the effectiveness of this medication. The Chronic Pain Medical Treatment Guidelines has the following regarding gabapentin: "Gabapentin has shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and it has been considered as a first line of treatment for neuropathic pain." Given the patient's continued complaints of pain, gabapentin may be warranted. However, the Chronic Pain Medical Treatment Guidelines requires documentation of pain assessment of functional changes or functional improvement when medications are used for chronic pain. In this case, review of ten

progress reports does not indicate that this patient is getting any benefit from this medication. The request for Gabapentin 300 mg, 180 count, is not medically necessary or appropriate.