

Case Number:	CM13-0018199		
Date Assigned:	10/11/2013	Date of Injury:	05/26/1981
Decision Date:	01/13/2014	UR Denial Date:	08/16/2013
Priority:	Standard	Application Received:	08/29/2013

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 Orthopedic Surgery 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 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 55 year old female who reported injury due to repetitive motions from 05/26/1981 to 03/27/2012. She first sought treatment for her injuries in approximately March or April of 2012. At that time, she was diagnosed with unspecified bulging discs as found on MRI and was prescribed unspecified medications for pain and sleep, as well as physical therapy, and work restrictions. The 24 sessions of physical therapy enabled the patient to end the use of a cane when ambulating and decreased symptoms. In May of 2012, she was seen by another physician who recommended epidural steroid injections to the lower back. In June of 2012, she was noted to have subjective right sided radicular symptoms to the L5 dermatome with a normal EMG, which later was described as pseudo-radiculopathy. She was given instructions on exercise, additional unspecified medications, an additional 8 sessions of physical therapy, and a TENS unit. At this time, she was determined to be temporarily totally disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for Amitriptyline HCL 10mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Insomnia..

Decision rationale: According to a clinical note from the pain management doctor dated 02/13/2013, the amitriptyline 10mg is prescribed for "sleep", not for chronic pain. The California MTUS and ACOEM guidelines did not specifically address the use of amitriptyline as it relates to insomnia; therefore, the Official Disability Guidelines were supplemented. The Official Disability Guidelines recommend that insomnia be treated based on the etiology, and that pharmacological agents should only be used after a thorough evaluation of the possible causes of the patient's sleep disturbances. During this exam, the specific components of insomnia should be addressed to include sleep quality, sleep onset, sleep maintenance, and next day functioning. Follow up documentation to this exam should include evidence of reduced time in sleep onset, improved sleep maintenance, avoidance of residual effects, and improvement in next day functioning. Guidelines also state that prescribing medications indefinitely will not work, and that patients do better in the long term if medication is stopped after a few weeks and no later than after 6 weeks, with continued assistance from use of cognitive behavioral therapy. In the records reviewed, it is noted that the patient has been taking medications for sleep since May of 2012. This exceeds guideline recommendations of 6 weeks. There was also no evidence of a thorough examination done to determine etiology of insomnia, nor were there interim evaluations determining efficacy of the medication therapy. Therefore, the request for amitriptyline 10mg is non-certified

1 prescription for Fexmid 7.5mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: The California MTUS Guidelines recommend muscle relaxants as a second line, short-term treatment of acute exacerbations of muscle spasms in patients with chronic low back pain. Guidelines also state that they show no benefit beyond the use of NSAIDs, their prolonged use over time can result in decreased efficacy, and they may lead to dependence. Fexmid in particular, is not recommended for chronic use and should be stopped after 2-3 weeks of treatment. The clinical note dated 12/13/2013 states that the patient had been taking unspecified muscle relaxants since April of 1012. This duration far exceeds the recommended guidelines for short-term use, and there were no interim reports providing objective evidence of the medication efficacy. Therefore, the request for Fexmid 7.5mg is non-certified.

1 prescription for Medi-Derm Cream 240 gm: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: California MTUS Guidelines recommend topical analgesics for neuropathic pain when primary and secondary treatments have failed. There was no documentation of objective findings of neuropathic pain included in the medical records. Also, the active ingredients in Medi-derm Cream are capsaicin 0.035%, menthol 5%, and methyl salicylate 20%. According to the California MTUS Guidelines, capsaicin is recommended only if other treatment options have failed. Also, evidence suggests that an increase over a 0.025% formulation would not provide any further benefit. Therefore, due to the lack of objective findings of neuropathic pain, evidence that other treatment options have failed, and an excessive formulation of capsaicin, the request for Medi-derm cream is non-certified.

1 prescription for Xodol 5/300mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

Decision rationale: California MTUS Guidelines list criteria for ongoing management of opioids which include objective evaluation of pain relief and drug screening. They also state that if there is failure to respond to the medication, alternative therapies should be considered. In the medical records provided for review, there was no evidence of any urine drug screens, and no measurable evidence of improved pain levels or function. As such, the request for Xodol 5/300mg is non-certified.