MAXIMUS Federal Services

Case Number:	CM13-0021287		
Date Assigned:	11/08/2013	Date of Injury:	06/19/2009
Decision Date:	01/27/2014	UR Denial Date:	08/09/2013
Priority:	Standard	Application Received:	09/07/2013

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 & Rehabilitation, and is licensed to practice in Oklahoma, 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 30-year-old male who reported a work-related injury on 06/19/2009 as the result of a fall. Subsequently, the patient presents with low back pain, head pain, and neck pain. The specific treatable diagnoses are lumbar spondylosis with myelopathy and chronic pain syndrome. The clinical note dated 07/30/2013 reports the patient was seen for follow-up under the care of [redacted]. The provider documents that the patient presents with complaints of back and neck pain rated at an 8/10. The provider reported the patient's current medication regimen includes Cymbalta 30 mg 2 tabs a day, Pamelor 10 mg 1 tab by mouth at bedtime, Relafen 750 mg 1 tab by mouth every day, Norco 10/325 mg 2 to 3 tabs a day, Skelaxin 800 mg 1 tab as needed, Prilosec 20 mg 1 tab by mouth every day, Senokot 8.6 mg 2 tabs every day, and Cialis as needed. The provider is recommending the patient undergo blood tests to monitor kidney and liver function. The provider documented the patient would be decreasing use of Relafen to 1 tab by mouth every day.

IMR ISSUES, DECISIONS AND RATIONALES

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

Skelaxin 800 mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61.

Decision rationale: The request for Skelaxin 800 mg is non-certified. The clinical documentation submitted for review lacks evidence to support the long-term necessity of this medication for the patient's use. The clinical notes document the patient's physical exam findings revealed painful range of motion and tenderness upon palpation. The provider documents the patient's medication usage decreases his pain complaints. However, California MTUS indicates Skelaxin is recommended with caution as a second line option for short-term pain relief in patients with chronic low back pain. This medication is not indicated for chronic use. Quantifiable evidence of the patient's reports of efficacy with his current medication regimen was not documented in the clinical notes reviewed. There was a lack of documentation of increase in objective functionality and decrease in the patient's rate of pain on a VAS scale. Given all the above, the request for Skelaxin 800 mg is neither medically necessary nor appropriate.

Cialis 5 mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Antidepressants for chronic pain .

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drug package insert online edition

Decision rationale: The request for Cialis 5 mg is non-certified. The provider documents the patient was to utilize Cialis 5 mg by mouth as needed. The current medication is not detailed in California MTUS/ACOEM or Official Disability Guidelines. The drug package insert for Cialis indicates Cialis is supported for the treatment of men with erectile dysfunction, men with the signs and symptoms of benign prostatic hyperplasia. The clinical notes document the patient has been utilizing opioids chronic in nature, and it is unclear how long the patient has utilized Cialis for his erectile dysfunction. Clinical notes did not indicate any recent diagnostic laboratory value to evidence the patient has any issues with his testosterone levels to support the requested medication. Given the entire above, request for Cialis 5 mg is neither medically necessary nor appropriate.

Pamelor 10 mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Antidepressants for chronic pain .

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 14.

Decision rationale: The request for Pamelor 10 mg is non-certified. The clinical documentation submitted for review lacks evidence to support the long-term necessity of this medication for the patient's use. The clinical notes document the patient's physical exam findings revealed painful

range of motion and tenderness upon palpation. The provider documents the patient's medication usage decreases his pain complaints. However, California MTUS indicates tricyclic antidepressants are recommended over selective serotonin reuptake inhibitors unless adverse reactions are a problem. Tricyclic antidepressants are supported for patients with neuropathic complaints. The clinical notes failed to document the patient presents with any neuropathic pain complaints, or quantifiable evidence of efficacy of the patient's medication regimen as documented by decrease in rate of pain or increase in objective functionality. Given all the above, the request for the request for Pamelor 10 mg is neither medically necessary nor appropriate.

Relafen 750 mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72.

Decision rationale: The request for Relafen 750 mg is non-certified. The clinical documentation submitted for review lacks evidence to support the long-term necessity of this medication for the patient's use. The clinical notes document the patient's physical exam findings revealed painful range of motion and tenderness upon palpation. The provider documents the patient's medication usage decreases his pain complaints. The clinical documents fail to evidence the patient's response to his current medication regimen, as documented by a decrease in rate of pain on a VAS scale and increase in objective functionality. Clinical notes did not indicate how long the patient had been utilizing this medication with quantifiable documentation of efficacy. Therefore, given the above, the request for Relafen 750 mg is neither medically necessary nor appropriate.