

Case Number:	CM13-0028204		
Date Assigned:	11/22/2013	Date of Injury:	02/13/2004
Decision Date:	06/23/2014	UR Denial Date:	09/23/2013
Priority:	Standard	Application Received:	09/23/2013

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 & Rehabilitation 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 injured worker is a 54-year-old female who reported an injury on February 13, 2004 secondary to an unknown mechanism of injury. The injured worker was evaluated on June 25, 2013 for reports of severe intractable low back pain as well as neck and right upper extremity pain with ongoing weakness. The injured worker reported the pain to be a 9/10 with the use of medications and a 10/10 without the use of medications. The exam noted spasms to the lower lumbar region with limited range of motion in all directions and a positive straight leg raise bilaterally. There was marked weakness in both lower extremities with the peroneus longus brevis bilaterally at 4/5, extensor hallucis longus on the left at 2/5 and the right at 4/5 and the tibialis anterior bilaterally at 4/5. There was a decreased Achilles reflex noted at 1+ on the right and absent on the left and hypoesthesia on the left at the L5 and S1 dermatomes. The diagnoses included low back and bilateral extremity pain, lumbar spine sprain/strain, status post L4-5 and L5-S1 discectomy, cervical spine sprain/strain and bilateral carpal tunnel syndrome. The treatment plan included continued medication therapy. The Request for Authorization and the rationale for the request were not in the documentation provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

NUCYNTA: 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 Chronic Pain Medical Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The request for Nucynta is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of significant evidence of an objective evaluation of risk for aberrant drug use behavior. There is no evidence of urine drug screen in the last year. There is a significant lack of evidence of the efficacy of the medication as the injured worker indicated a pain level of 9/10 with medication. Therefore, based on the documentation provided, the request is not medically necessary.

GABAPENTIN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ganapentin, Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Antiepilepsy Drugs Page(s): 16-22.

Decision rationale: The request for Gabapentin is not medically necessary. The California MTUS Guidelines state that gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. There is a significant lack of evidence of the efficacy of the medication as the injured worker indicated a pain level of 9/10 with medication. There is also a lack of evidence of neuropathic pain. Therefore, the request is not medically necessary.

CELEBREX: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: The request for Celebrex is not medically necessary. The California MTUS Guidelines state the use of NSAIDs is recommended as an option for short-term symptomatic relief of pain. However, There is a significant lack of evidence of the efficacy of the medication as the injured worker indicated a pain level of 9/10 with medication. Therefore, based on the documentation provided, the request is not medically necessary.

LIDODERM PATCHES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The request for Lidoderm patches is not medically necessary. The California MTUS Guidelines state that Lidoderm is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. There is a lack of objective evidence of peripheral pain. There is also a lack of evidence of efficacy of the medication. Therefore, the request is not medically necessary.

DENDRACIN LOTION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The request for Dendracin Lotion is not medically necessary. The California MTUS Guidelines recommend capsaicin only as an option in patients who have not responded or are intolerant to other treatments. The guidelines further state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is a lack of clinical evidence of efficacy of other treatments in the documentation provided. Therefore, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR ROM TESTING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, ,

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

Decision rationale: The request for retrospective request for rom testing is not medically necessary. The Official Disability Guidelines state ROM testing is not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. The guidelines further state that computerized measures of range of motion are not recommended. Therefore, the request is not medically necessary.