

Case Number:	CM13-0042382		
Date Assigned:	12/27/2013	Date of Injury:	10/28/2011
Decision Date:	04/10/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/17/2013

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 Internal Medicine, 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 male who was injured on 10/28/2010 while he was stripping the bathroom floor. He was pulling the machine up the stairs by himself. 08/26/2013 Medications Include: Vicodin 5mg Zanaflex 4mg Anaprox 550 07/12/2013 Medications Include: Vicodin 5mg Zanaflex 4mg Anaprox 550 04/26/2013 Medications Include: Tylenol #3-Discontinued Norflex PR2 dated 09/24/2013 indicate the patient's symptoms are unchanged. He was awaiting authorization for more treatment. Objective findings on exam revealed tenderness of the lumbar spine paraspinal muscles with guarding and spasm. There was positive straight leg raise; bilateral knees revealed tenderness medial and laterally joint. The patient was diagnosed with 1) discosteophyte 2) stenosis/facet osteoarthritis 3) bilateral knee PFA/OA and 4) Bilateral mild CTS. There was no documentation of medications he is taking 5) bilateral elbow medial epicondyle (illegible) 6) stress and anxiety. Follow up evaluation on 08/26/2013 indicated the patient reported continued low back pain with bilateral lower extremity radicular pain, right greater than left. He was having failed conservative treatment; the patient expressed his desire to proceed with pain management consultation in consideration of injection treatment to the lumbar spine. Clinical findings revealed tenderness to palpation with mild spasm over the paraspinal musculature. He had active ranges of motion of the lumbar spine was decreased. His straight leg raising test was positive bilaterally. PR2 dated 08/26/2013 indicated the patient was having continued low back pain until (illegible). Objective findings on exam revealed tenderness to palpation of the lumbar spine with mild spasm; SLR (Illegible); right greater than left. The patient's treatment plan consisted of: 1) discontinue Vicodin and start Tramadol; 2) Discontinue Zanaflex and start Fexmid 7.5 mg. PR2 dated 07/12/2013 documented the patient's complaints are unchanged. Objective findings on exam revealed the lumbar spine to tender to palpation and (written note illegible); bilateral knees are (written note illegible). The patient has completed 6

therapy visits to hands with temporary improvement. The treatment plan indicated the patient's meds were declined for refills and he wants to discontinue the use of (medication illegible)

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ANTIDEPRESSANTS FOR CHRONIC PAIN, Page(s): 13-15.

Decision rationale: The guidelines indicate anti-depressants may be recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain, for certain conditions. According to the guidelines, Amitriptyline is a tricyclic antidepressant, and tricyclics are generally considered first-line agents unless they are ineffective, poorly tolerated, or contraindicated. The medical records do not document the patient's current medication regimen with detailed assessment of his response to usage. In absence of this information, introducing additional medications is not supported by the evidence based literature. Furthermore, the PR2 dated 09/24/2013 demonstrated tenderness on examination; it does not reveal subjective report and objective findings indicative of chronic pain or neuropathic pain unresponsive to other interventions. Therefore, the medical necessity of Amitriptyline has not been established.

Dextromethorphan: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [HTTP://WWW.DRUGS.COM/DEXTRUMETHORPHAN.HTML](http://www.drugs.com/dextrumethorphan.html).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: MEDLINE PLUS.

Decision rationale: According to the medical literature, Dextromethorphan is used to temporarily relieve cough caused by the common cold, the flu, or other conditions. The medical records do not document any subjective complaints of symptoms with clinical findings, as to establish the need for this medication. The medical necessity of Dextromethorphan has not been established.

Tramadol: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS, CRITERIA FOR USE, Page(s): 76-79.

Decision rationale: The guidelines note, opioid medications, such as Tramadol may be efficacious for short-term use, but the efficacy of long-term use is limited. The 09/24/2013 progress report documents subjective tenderness on examination, it does not document the patient's pain levels or response to medication use and other non-invasive self-care measures, or objective findings as to substantiate the existence of moderate to moderately severe pain to support the use of Tramadol. According to the Chronic Pain Medical Treatment Guidelines, continued opioid treatment requires documented pain and functional improvement and response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The medical records do not establish these requirements have been met. Therefore, the medical necessity of tramadol has not been established.

Pencream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, COMPOUNDED TREATMENTS Page(s): 111-113. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: DRUGS & MEDICATIONS -PENCREAM COMPOUNDING AGENT MISC, [HTTP://WWW.WEBMD.COM/DRUGS/DRUG](http://www.webmd.com/drugs/drug).

Decision rationale: Pencream is a compounding agent; its medical indication has not been clearly identified for the patient. Therefore, the medical necessity of Pencream is not established.

Diclofenac: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, Page(s): 111-112.

Decision rationale: According to the guidelines, topical analgesics are considered to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Diclofenac is a topical medication, indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. The medical records do not establish the existence of subjective complaints with correlating objective clinical and radiographic findings that substantiate the

necessity of this product. Therefore, the medical necessity of Diclofenac has not been established.

Flurbiprofen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, NSAIDS, SPECIFIC DRUG LIST & ADVERSE EFFECTS Page(s):.

Decision rationale: According to the guidelines, oral Flurbiprofen is indicated for the management of Osteoarthritis and mild to moderate pain. The dosage and intended purpose of this request has not been documented. It is unclear if the medication is indicated as an oral or in a topical compound. Therefore, the medical necessity of Flurbiprofen is not established.