

Case Number:	CM13-0046438		
Date Assigned:	12/27/2013	Date of Injury:	01/28/2002
Decision Date:	03/07/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	11/12/2013

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 and Rehabilitation and is licensed to practice in Oklahoma and 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 61-year-old female who reported an injury on 01/28/2001 due to cumulative trauma which reportedly caused injury to her neck, low back, left shoulder, and left leg. Prior treatments included physical therapy, medications, and acupuncture. The patient's medication management was monitored for aberrant behavior with urine drug screens. The patient's most recent clinical examination findings included the patient had 7/10 pain and that the patient was taking Norco 7.5/325 mg 2 per day, Flexeril as needed for spasms, and a topical analgesic. It was noted that the patient's medications assist with pain reduction and allow for participation in activities of daily living. The patient's diagnoses included degenerative disc disease and facet arthropathy of the lumbar spine, left shoulder impingement, radicular symptoms in the left upper extremity and left lower extremity, chronic pain syndrome, and diabetes mellitus uncontrolled. The patient's treatment plan included continuation of the medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325mg #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Hydrocodone/APAP 10/325 mg #60 with 2 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the continued use of opioids in the management of the patient's chronic pain be supported by a quantitative assessment of pain relief, documentation of functional benefit, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient's medications allow for increased functionality and that the patient is monitored for aberrant behavior with urine drug screens. However, the clinical documentation submitted for review fails to provide a quantitative assessment of pain relief. As there is not a quantitative assessment, there is no way to determine the efficacy of this medication. Additionally, the requested 2 refills does not allow for adequate reassessment and evaluation of the efficacy for this medication. As such, the requested Hydrocodone/APAP 10/325 mg #60 with 2 refills is not medically necessary.

Terocin pain patch box with 2 refills: Upheld

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

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

Decision rationale: The requested Terocin pain patch box with 2 refills is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. However, the requested medication contains Methyl Salicylate, Capsaicin, Menthol, and Lidocaine. The California Medical Treatment Utilization Schedule does recommend Methyl Salicylate and Menthol in the management of a patient's osteoarthritic pain. However, Capsaicin as a topical agent is not recommended unless there is failure to respond to other first-line treatments. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to other treatments. Additionally, the use of Lidocaine in a patch form must be supported by a quantitative pain assessment and documentation of functional benefit. The clinical documentation submitted for review does provide evidence that the patient does have increased functionality. However, the documentation does not include a quantitative pain assessment to establish the efficacy of this medication. Therefore, continued use would not be supported. As such, the requested Terocin pain patch box with 2 refills is not medically necessary or appropriate.

Cyclobenzaprine 7.5mg #30 with 2 refills: 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.

Decision rationale: The requested Cyclobenzaprine 7.5 mg #30 with 2 refills is not medically necessary or appropriate. The clinical documentation submitted for review does indicate the patient has been on this medication for an extended duration of time. However, California Medical Treatment Utilization Schedule only recommends this medication for short courses of treatment. The California Medical Treatment Utilization Schedule does not recommend duration to exceed 2 to 3 weeks. The requested medication with 2 refills exceeds this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested Cyclobenzaprine 7.5 mg #30 with 2 refills is not medically necessary or appropriate.