

<b>Case Number:</b>	CM13-0046952		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	07/16/2010
<b>Decision Date:</b>	03/06/2014	<b>UR Denial Date:</b>	10/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

### 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 has a subspecialty in Spine Surgery and is licensed to practice in Texas and 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 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 53-year-old injured worker who reported an injury on 07/16/2010. The mechanism of injury was not provided. The patient was noted to have ongoing and debilitating pain in the low back radiating to both lower extremities. The patient was noted to undergo an epidural steroid injection at S1 bilaterally on 03/25/2013 which provided 70% relief to the low back, as well as to their radicular symptoms in the lower extremities. The patient was noted to have significant pain in other parts of their body which made it difficult for him to function throughout the day. The patient was noted to suffer with a diagnosed cervical cord myelopathy with central cord syndrome and it was noted the patient underwent an anterior cervical fusion at C2-7 on 08/27/2011. The patient was noted to be a high fall risk and use a wheelchair. The patient was noted to have several falls while ambulating in his home and the patient stated they are mostly homebound. The patient was noted to have knee surgery in the past and was noted to have positive crepitus in the right knee. The patient was noted to have tenderness to palpation along the medial and lateral joint line of the left knee. Diagnoses were noted to include cervical myoligamentous injury with bilateral upper extremities radicular symptoms, central cord myelopathy with central cord syndrome, bilateral internal knee derangement, right knee arthroscopic surgery 01/13/2011, and left knee total arthroplasty 06/10/2011, as well as L5-S1 fusion in 1996. The patient was additionally noted to have GI distress with nausea and vomiting. The request was made for medication refills, as well as physical therapy, a chair lift with recliner, a handicap accessible van with a left/lift, and a follow-up office visit with the spinal surgeon.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anaprox DS 550mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anaprox Page(s): 72-73.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines indicate that Anaprox is a nonsteroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis and they recommend the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. The clinical documentation submitted for review failed to provide the efficacy of the requested medication. Additionally, the submitted request failed to indicate the quantity of the medication being requested. The request for Anaprox DS 550mg is not medically necessary and appropriate.

**Fexmid 7.5mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41, 64.

**Decision rationale:** The California MTUS states that Cyclobenzaprine is recommended for a short course of therapy. Flexeril is more effective than placebo in the management of back pain; however, the effect is modest and comes at the price of greater adverse effects. This medication is not recommended to be used for longer than 2-3 weeks. The clinical documentation submitted for review indicated that the patient gets significant muscle spasms and requires this medication on a daily basis. However, there was lack of documentation indicating the efficacy of the requested medication. There was also lack of documentation indicating the quantity of medication being requested. The request for Fexmid 7.5mg is not medically necessary and appropriate.

**Roxicodone 15mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone, pg. 75, Ongoing Management, pg. 78 Page(s): 78.

**Decision rationale:** The California MTUS guideline recommend Oxycodone for controlling chronic pain and this medication is often used for intermittent or breakthrough pain. California

MTUS recommend that there should be documentation of the 4 A's for Ongoing Monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The clinical documentation submitted for review failed to provide documentation of the "4 A's." Additionally, there was lack of documentation indicating the quantity of medication being requested. The request for Roxicodone 15mg is not medically necessary and appropriate.

**Colace 100mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Initiation of Opioid Therapy Page(s): 77.

**Decision rationale:** According to the California MTUS when initiating opioid therapy, prophylactic treatment of constipation should be initiated. The clinical documentation submitted for review failed to indicate the patient had signs or symptoms of constipation. Additionally, it failed to provide the efficacy of the requested medication and it did not provide the number of Colace being requested. The request for Colace 100mg, is not medically necessary and appropriate.

**Dendracin topical analgesic cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylates, pg. 105, Topical Analgesics, pg. 111, Page(s): 105, 111. Decision based on Non-MTUS Citation Dendracin, Online Drug Insert.

**Decision rationale:** The California MTUS guidelines do not specifically address Dendracin. However, per the online drug insert, Dendracin includes methyl salicylate, Benzocaine and menthol and it is used for: Temporary relief of minor aches and pains caused by arthritis, simple backache, and strains. According to the California MTUS, Topical Salicylates are recommended and topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The clinical documentation submitted for review failed to provide documentation of a trial of antidepressants and anticonvulsants that had failed. Additionally, there was lack of documentation per the submitted request for the quantity of Dendracin being requested. The request for Dendracin topical analgesic cream, is not medically necessary and appropriate.

**Prilosec 20mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

**Decision rationale:** The California MTUS recommends PPIs for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the patient had nausea and vomiting. However, it failed to provide documentation of the efficacy of the requested medication. There was lack of documentation indicating the quantity of Prilosec being requested. The request for Prilosec 20mg is not medically necessary and appropriate.

**Nuvigil 250mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** The Official Disability Guidelines (ODG) does not recommend Nuvigil to counteract sedating effects of narcotics. The physician indicated the request for the medication was due to daytime somnolence. There is a lack of documentation indicating the efficacy of the requested medication. The request for Nuvigil 250 mg #30 is not medically necessary and appropriate.

**Prozac 20mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (selective serotonin reuptake inhibitors Page(s): 107.

**Decision rationale:** The California MTUS guidelines indicate that SSRIs are not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. SSRIs have not been shown to be effective for low back pain. The clinical documentation submitted for review failed to provide the efficacy and the rationale for the use of this medication. There was lack of documentation indicating the quantity of pills being requested. The request for Prozac 20mg is not medically necessary and appropriate.

**Physical therapy two times a week for six weeks for the lumbar and cervical spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines states that physical medicine with passive therapy can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. Treatment is recommended with a maximum of 9-10 visits for myalgia and myositis and 8-10 visits may be warranted for treatment of neuralgia, neuritis, and radiculitis. The clinical documentation submitted for review failed to provide the objective functional benefit of the prior physical therapy and the number of sessions the patient had. As the patient's injury was noted to have been reported on 07/16/2010, the patient should be well versed in a home exercise program. The request for physical therapy two times a week for six weeks for the lumbar and cervical spine is not medically necessary and appropriate.

**Chair lift with recliner:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation the Blue Cross of California Policy Durable Medical Equipment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation the Official Disability Guidelines (ODG), Knee & Leg Chapter, DME.

**Decision rationale:** The Official Disability Guidelines (ODG) recommend durable medical equipment if there is a need and if the device or system meets Medicare's definition of durable medical equipment which includes: can withstand repeated uses, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the patient's home. The clinical documentation submitted for review failed to provide that this request was for a device that is primarily and customarily used to serve a medical purpose and is generally not useful to a person in the absence of illness or injury. The physician indicated that the request was made as the patient was unable to get up and out of a chair, however, was noted to be ambulatory. The request for a chair lift with recliner is not medically necessary and appropriate.

**Handicap accessible van with a left/lift:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation online source:  
[http://www.medicaremd.com/coverage\\_noncovered\\_equipment.asp](http://www.medicaremd.com/coverage_noncovered_equipment.asp).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, DME.

**Decision rationale:** The Official Disability Guidelines recommend durable medical equipment if there is a need and if the device or system meets Medicare's definition of durable medical equipment which includes: can withstand repeated uses, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the patient's home. The clinical documentation submitted for review indicated the patient was ambulatory, however, the patient was noted to have severe debilitating chronic pain. There is lack of documentation indicating that a van would be primarily and customarily used to serve a medical purpose and was not useful to a person in the absence of illness or injury. The request for handicap accessible van with left/lift is not medically necessary and appropriate.

**Follow up with** [REDACTED] **orthopedic spine surgeon: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**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 Chapter, Office Visits.

**Decision rationale:** The Official Disability Guidelines indicate the need for a clinical visit with a healthcare provider is individualized based upon review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgement. This request was noted to be made regarding cervical spine stabilization. However, there was lack of documentation indicating the necessity for the request. The request for follow up with [REDACTED] [REDACTED] orthopedic spine surgeon is not medically necessary and appropriate.