

Case Number:	CM13-0048116		
Date Assigned:	12/27/2013	Date of Injury:	05/10/2009
Decision Date:	02/28/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	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 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 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 41-year-old who reported an injury on 05/10/2009. The patient is diagnosed with degenerative disc disease in the lumbar spine with radiculopathy, lower extremity neuropathic pain with worsening paresthesia and weakness, intolerance to oral NSAIDs, and multiple herniated nucleus pulposus of the lumbar spine. The patient was seen by [REDACTED] on 10/03/2013. The patient reported persistent pain with activity limitation. Objective findings included a non-antalgic gait, diffuse tenderness to palpation of the lumbar spine, diminished sensation, and decreased strength. The treatment recommendations included continuation of current medications including Terocin patch, hydrocodone, omeprazole, cyclobenzaprine, and amitriptyline.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin pain patch, one box of ten patches: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state 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. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient has continued to report high levels of pain with activity limitation. Additionally, there is no evidence of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. The request for Terocin pain patch, one box of ten patches, is not medically necessary or appropriate.

Hydrocodone/Apap 7.5/325 mg, 130 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient has continuously reported high levels of pain with activity limitation. The patient's physical examination does not reveal any changes that would indicate functional improvement. Satisfactory response to treatment has not been indicated. The request for Hydrocodone/Apap 7.5/325 mg, 130 count, is not medically necessary or appropriate.

Omeprazole 20 mg, 60 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID (non-steroidal anti-inflammatory drug). There is no indication of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the use of a proton pump inhibitor. The request for Omeprazole 20 mg, 60 count, is not medically necessary or appropriate.

Cyclobenzaprine 7.5 mg, 60 count: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent high levels of pain with activity limitation. There is no evidence of palpable muscle spasm, spasticity, or muscle tension upon physical examination. As Guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. The request for Cyclobenzaprine 7.5 mg, 60 count, is not medically necessary or appropriate.

Amitriptyline HCL 10 mg, 60 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13 - 16.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Amitriptyline is indicated for neuropathic pain. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report high levels of pain with activity limitation. There has been no change in the patient's physical examination that would indicate functional improvement. It is also noted on 10/03/2013, the patient's urinalysis was inconsistent for amitriptyline. The request for Amitriptyline HCL 10 mg, 60 count, is not medically necessary or appropriate.