

Case Number:	CM13-0052180		
Date Assigned:	12/27/2013	Date of Injury:	05/15/1998
Decision Date:	03/18/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/15/2013

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 Anesthesiology has a subspecialty in Pain Management and is licensed to practice in Florida. 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 54-year-old male who reported an injury on 05/15/1999. The mechanism of injury was not provided for review. The patient's most recent clinical examination revealed that the patient had 9/10 pain in the low back that radiated into the bilateral lower extremities. The patient's medications included Celebrex, Baclofen, Xanax, Lactose, Soma, Norco, Androgel, and an intrathecal pain pump. The patient's treatment plan included continuation of medications and a pain pump refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325mg: 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 Section Opioids On-Going Management Page(s): 78.

Decision rationale: The requested Hydrocodone/APAP 10/325 mg 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. California Medical Treatment Utilization Schedule recommends the use of opioids in the management of a 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 not provide any evidence that the patient has any pain relief from the prescribed medication schedule. The patient consistently has 9/10 VAS pain scores. Additionally, there is no documentation of functional benefit or that the patient is monitored for aberrant behavior. Therefore, continued use of this medication would not be supported. As such, the requested Hydrocodone/APAP 10/325 is not medically necessary or appropriate.

AndroGel 1%: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult, Mosby, Inc.

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, Testosterone

Decision rationale: The requested AndroGel 1% is not medically necessary or appropriate. Official Disability Guidelines do recommend the use of testosterone replacement therapy when there is evidence of reduced testosterone related to medication usage. The clinical documentation submitted for review does indicate that the patient is on high doses of opioids that would contribute to decreased testosterone levels. However, the clinical documentation submitted for review does not provide any documentation of functional benefit or symptom relief as a result of the use of this medication. Therefore, continued use would not be indicated. As such, the requested AndroGel 1% is not medically necessary or appropriate.

Baclofen 10mg: 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 Muscle Relaxants Page(s): 63.

Decision rationale: The requested Baclofen 10 mg is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration of time. Chronic Pain Medical Treatment Guidelines recommend the use of muscle relaxants for long periods of treatment. Chronic Pain Medical Treatment Guidelines recommends durations of treatment not to exceed 2 to 3 weeks. The patient has been on this medication longer than the recommended time frame and there are no exceptional factors noted to support extending treatment beyond recommendations; continued use would not be supported. As such, the requested Baclofen 10 mg is not medically necessary or appropriate.

Alprazolam .05mg: 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 Section Benzodiazepines Page(s): 24.

Decision rationale: The requested Alprazolam 0.5mg is not medically necessary or appropriate. Chronic Pain Medical Treatment Guidelines does not recommend the extended use of benzodiazepines as there is high risk of physical and psychological dependence. The clinical documentation does support that the patient has been on this medication for an extended duration of time. Therefore, continued use would not be supported. As such, the requested alprazolam 0.5 mg is not medically necessary or appropriate.

Generalt 10mg/15ml: 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 Opioids, Initiating Therapy Page(s): 77.

Decision rationale: The requested "Generlat" (generlac) 10 gm/15ml is not medically necessary or appropriate. Chronic Pain Medical Treatment Guidelines does recommend prophylactic use of medications for constipation when the patient is on chronic opioid therapy. However, the clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support continued deficits that would require continued medication management. Therefore, the continued use of this medication would not be indicated. As such, the requested "Generlat" (generlac) 10gm/15ml is not medically necessary or appropriate

Sertraline 100mg: 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 Medications for Chronic Pain and Antidepressants for chronic pain Page(s): 60,13.

Decision rationale: The requested Sertraline 100 mg is not medically necessary or appropriate. Chronic Pain Medical Treatment Guidelines does recommend antidepressants as a first line medication in a patient's chronic pain. However, Chronic Pain Medical Treatment Guidelines recommends continued use of medications in the management of chronic pain be supported by a quantitative assessment of symptom relief and documentation of functional benefit. The clinical documentation submitted for review does not provide any evidence that the patient receives any pain relief as the patient's VAS pain scores are consistently 9/10. Additionally, there is no

documentation of functional benefit related to medication usage. Therefore, continued use would not be indicated. As such, the requested Sertraline 100 mg is not medically necessary or appropriate.

Celebrex 200mg: 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 Medications for Chronic Pain and NSAIDs (non-steroidal anti-inflammatory drugs), Page(s): 60,67.

Decision rationale: The requested Celebrex 200 mg is not medically necessary or appropriate. Chronic Pain Medical Treatment Guidelines does recommend nonsteroidal anti-inflammatory drugs for pain control. However, Chronic Pain Medical Treatment Guidelines also states that continued use of medications for the management of a patient's chronic pain must be supported by documentation of functional benefit and an assessment of pain relief. The clinical documentation submitted for review does not provide any evidence that the patient has any functional benefit related to medication usage. Additionally, there is no documentation that the patient receives any pain relief as a result of the medication usage as the patient consistently has VAS pain scale scores rated at a 9/10. Therefore, continued use would not be indicated. As such, the requested Celebrex 200 mg is not medically necessary or appropriate.

Pain Pump Hydromorphone/Baclofen/Bupivacaine: 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 Implantable drug-delivery systems Page(s): 52.

Decision rationale: The requested pain pump is not medically necessary or appropriate. Chronic Pain Medical Treatment Guidelines recommends intrathecal pain pumps as an end stage treatment for chronic pain. However, the clinical documentation submitted for review does not reflect any pain relief or functional benefit from the previous pain pump refills. Therefore, an additional pain pump refills. Therefore, an additional pain pump refill will not be supported. As such, the requested pain (Hydromorphone/Baclofen/Bupivacaine) is not medically necessary or appropriate.