

Case Number:	CM13-0057860		
Date Assigned:	12/30/2013	Date of Injury:	10/08/1986
Decision Date:	05/08/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	11/25/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 52-year-old male who reported an injury on 10/08/1986. The mechanism of injury was not provided for review. The injured worker ultimately underwent L4-5 and L5-S1 fusion followed by the development of complex regional pain syndrome. The injured worker's treatment history included lumbar sympathetic blocks and a failed spinal cord stimulator implantation. The injured worker was evaluated on 09/18/2013. It was documented that the injured worker had pain rated at a 7.5/10 without any changes in pain. It was noted that the injured worker regularly took his medications and was monitored for aberrant behavior with urine drug screens. The injured worker's medications included Lidoderm 5%, Cymbalta 30 mg, Soma 350 mg, Lyrica 100 mg, Zanaflex 4 mg and Dilaudid 2 mg. Physical findings included limited range of motion of the lumbar spine secondary to pain with a positive facet loading bilaterally and tenderness to palpation over the metatarsal phalangeal joints of the 1st toe and plantar surface of the foot with no evidence of allodynia or hyperalgesia or hyperesthesia. It was noted that the injured worker had normal motor strength bilaterally in the lower extremities. The injured worker's diagnoses included lumbar radiculopathy, reflex sympathetic dystrophy of the lower limb, post lumbar laminectomy syndrome, and low back pain. The injured worker's treatment plan included a medication refill, to assist with pain control.

IMR ISSUES, DECISIONS AND RATIONALES

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

LIDODERM 5% #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS; MEDICATIONS FOR CHRONIC PAIN Page(s): 111; 60.

Decision rationale: The requested Lidoderm 5% #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of medications for chronic pain be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review indicates that the injured worker has been on this medication since at least 09/2012. The injured worker's most recent clinical evaluation does not provide any evidence of a quantitative assessment to support pain relief or specific evidence of functional improvement related to the medication usage. Also, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Lidoderm 5% #90 is not medically necessary or appropriate.

ZANAFLEX 4MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN).

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

Decision rationale: The requested Zanaflex 4 mg #180 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication since at least 09/2012. California Medical Treatment Utilization Schedule does not recommend the long term use of muscle relaxants. California Medical Treatment Utilization Schedule recommends the use of muscle relaxants be limited to a short duration of treatment for acute exacerbations of chronic pain. The clinical documentation submitted for review does not support that the injured worker has suffered an acute exacerbation of chronic pain. Additionally, as the injured worker has been on this medication for an extended period of time, continued use would not be supported. Also, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Zanaflex 4 mg #180 is not medically necessary or appropriate.

SOMA 350MG #30: Upheld

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

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

Decision rationale: The requested Soma 350 mg #30 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 09/2012. California Medical Treatment Utilization Schedule does not recommend the extended use of muscle relaxants for chronic pain. California Medical Treatment Utilization Schedule recommends muscle relaxants be limited to a duration of 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation does support that the injured worker has been on this medication for an extended duration of time therefore, continued use would not be supported. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested Soma 350 mg #30 is not medically necessary or appropriate.

DILAULID 2MG #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS; ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The requested Dilaudid 2 mg #180 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends continued use of opioids in the management of chronic pain be supported by documentation of functional benefit, evidence of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior without significant side effects. However, the clinical documentation submitted for review fails to provide any evidence that the injured worker has pain relief or significant functional benefit as a result of medication usage. Therefore, continued use of this medication would not be supported. As such, the requested Dilaudid 2 mg #180 is not medically necessary or appropriate.