

Case Number:	CM13-0058002		
Date Assigned:	12/30/2013	Date of Injury:	08/01/2002
Decision Date:	03/27/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	11/26/2013

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, has a subspecialty in Interventional Spine 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 60-year-old male with a date of injury of 08/01/2002. The listed diagnoses per [REDACTED] dated 11/06/2013 are low back pain syndrome, degenerative disk disease, lumbar spine, lumbar disk displacement, spinal stenosis, lumbar and facet arthropathy. According to report dated 11/06/2013 by [REDACTED], the patient presents with continued lumbar pain. The pain is described as sharp, aching, shooting, throbbing, burning, and stabbing. The patient states the least pain is 5/10, the average pain is 6/10, and the worse pain is 7/10. In the last month, without medication, the patient notes the least pain was 7/10 and the worse pain, 9/10. The patient states he can tolerate a pain level of 4/10. The patient was noted to be frustrated in the last 30 days due to the fact that TESI was ineffective. The patient states that therapy is producing fair results and is currently taking medications as prescribed. The provider requests Hydrocodone 10/325 #80 and Voltaren gel 1%. It was noted that the patient rotates between Lortab and Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone-Acetaminophen 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 88-89.

Decision rationale: This patient presents with chronic low back pain. The provider is requesting Hydrocodone 10/325 #180. Utilization review dated 11/18/2013 denied request stating, "There is no VAS quantification of pain with and without medications. There is no documented symptomatic or functional improvement from previous usage." For chronic opiate use, MTUS Guidelines page 88 and 89 require functioning documentation using a numerical scale or a validated instrument at least once every 6 months. Documentation of the 4As (analgesia, ADLs, adverse side effects, adverse behaviors) is required. Furthermore, under outcome measure, it also recommends documentation of current pain, average pain, least pain, time it takes for medication to work, duration of pain relief with medications, et cetera. The patient has written a letter of appeal stating that he is not a surgical candidate and medication is providing some quality of life. Unfortunately, the provider does not provide adequate documentation of this medication's efficacy in terms of pain assessment and functional changes as required by the MTUS. The recommendation is for denial.

Voltaren 1% 100: 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): 111-112.

Decision rationale: This patient presents with chronic low back pain. The provider is requesting Voltaren gel 1%. The California MTUS Guidelines state that efficacy in clinical trials for this topical NSAIDS modality has been inconsistent and most studies are small and of short duration. Indications are for osteoarthritis and tendinitis, in particular that of the knee and elbow and other joints that are amenable to topical treatment, recommended for short-term use 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for treatments of osteoarthritis of the spine, hip, or shoulder. As indicated in the provided medical records dating from 03/28/2013 to 11/06/2013, the patient presents with chronic lumbar spine complaints. The patient does not suffer from peripheral joint arthritis or tendinitis problems for which topical NSAIDs are indicated. The recommendation is for denial.

Cyclobenzaprine HCL 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 64.

Decision rationale: This patient presents with chronic low back pain. The provider is requesting Cyclobenzaprine. The California MTUS guidelines pg 64 states Cyclobenzaprine is recommended for a short course of therapy. "Limited, mixed-evidence does not allow for a

recommendation for chronic use." The California MTUS does not recommend long-term use of Cyclobenzaprine. The California MTUS recommends using 3-4 days for acute spasms and no more than 2-3 weeks. The requested Cyclobenzaprine is not medically necessary and recommendation is for denial.