

Case Number:	CM13-0058457		
Date Assigned:	12/30/2013	Date of Injury:	02/04/2008
Decision Date:	04/04/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	11/27/2013

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, 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 53-year-old female who reported an injury on 02/04/2008. The mechanism of injury was not provided for review. The patient ultimately developed chronic pain. The patient's treatment history included physical therapy, multiple medications, and epidural steroid injections. The patient's most recent clinical documentation noted that the patient had persistent low back complaints radiating into the lower extremity and neck pain radiating into the bilateral upper extremities. It was noted that the patient had 10/10 pain without medications that was reduced to a 7/10 with medications. Objective findings included limited lumbar range of motion secondary to pain and tenderness to palpation over the lumbar spine at the L4-S1 levels, myofascial tenderness and paraspinal muscle spasming with palpation in the lumbar region. The patient's diagnoses included lumbar radiculopathy, lumbar disc degeneration, lumbar spinal stenosis, osteoarthritis, chronic pain, insomnia secondary to chronic pain, status post left total knee arthroplasty, spondylolisthesis, and history of gastric bypass. The patient's treatment plan included medication refills. Medications included Exoten-C, Restone 3/100 mg, Senna, Cartivisc, Zolpidem, tizanidine, and Voltaren XR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Exoten-C lotion 120ml #120: 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.

Decision rationale: The requested Exoten-C lotion 120 mL #120 is not medically necessary or appropriate. The requested medication is a compounded topical analgesic that contains methyl salicylate, menthol, and capsaicin. California Medical Treatment Utilization Schedule does recommend the use of menthol and methyl salicylate in the management of osteoarthritic pain. The clinical documentation submitted for review any evidence that the patient's pain is osteoarthritic in nature. Additionally, California Medical Treatment Utilization Schedule does not recommend the use of capsaicin unless the patient has failed to respond to first-line analgesics. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to first-line antidepressants or anticonvulsants. Therefore, the use of capsaicin would not be supported. As such, the requested Exoten-C lotion 120 mL #120 is not medically necessary or appropriate.

Restone 3-100mg QHS #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MD Consult Drug Monograph

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, Insomnia Treatments

Decision rationale: The requested Restone 3/100 mg every night #30 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient is being prescribed this medication to assist with sleep hygiene related to chronic pain. Official Disability Guidelines recommends pharmacological management for insomnia complaints for patients who have failed to respond to non-pharmacological management. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to non-pharmacological interventions. Additionally, the clinical documentation notes that this patient has been on this medication for an extended duration. An adequate assessment of the patient's sleep hygiene was not provided for review to support continued use. Also, clinical documentation indicates that the patient is taking an additional sleep aid. Clinical documentation does not clearly identify the need for 2 different sleep aids to assist the patient with sleep hygiene. Therefore, the need for this medication is not clearly indicated. As such, the requested Restone 3/100 mg every night #30 is not medically necessary or appropriate.

Tizanidine 4mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

Decision rationale: The requested tizanidine 4 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends muscle relaxants for short durations of treatment for acute exacerbations of chronic pain. The clinical documentation submitted for review indicates that this patient has been on this medication since at least 05/2013. This well exceeds guideline recommendations of a 2 to 3 week duration of treatment. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested tizanidine 4 mg # 60 is not medically necessary or appropriate.

Voltaren 1% gel #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.

Decision rationale: The requested Voltaren 1% gel #100 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does support the use of this medication for short durations of treatment for patients who are intolerant of oral formulations of non-steroidal anti-inflammatory drugs. The clinical documentation submitted for review does not provide any evidence that the patient cannot tolerate oral formulations of this medication. Additionally, the clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested Voltaren 1% gel #100 is not medically necessary or appropriate.