

Case Number:	CM13-0065867		
Date Assigned:	05/07/2014	Date of Injury:	04/10/1991
Decision Date:	07/09/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/14/2013

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 and Rehabilitation, and is licensed to practice in Texas and Oklahoma. 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 who reported an injury on April 10, 1991. The mechanism of injury was not provided for review. The injured worker ultimately developed chronic low back pain that was managed with multiple medications. The injured worker was evaluated on November 12, 2013. It was documented that the injured worker had continued low back pain and was a candidate for a 2 level fusion surgery. The injured worker's medications included Norco 10/325 mg, Percocet 10/325 mg, Neurontin 300 mg, Xanax SR 1 mg, Adderall 20 mg, Dendracin topical analgesic cream. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker's diagnoses included a cervical spine sprain/strain, left shoulder internal derangement, lumbar spine sprain/strain, bilateral lower extremity radiculopathy, reactionary depression/anxiety, right knee sprain/strain, and medication induced gastritis. The injured worker's treatment plan included trigger point injections, an intra-articular knee injection, and continued medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

MS CONTIN 30 MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, INITIATING TREATMENT Page(s): 77.

Decision rationale: The clinical documentation submitted for review does not indicate that the injured worker is taking this medication. There is no justification for the request. The Chronic Pain Medical Treatment Guidelines recommends initiation of opioids is supported by documentation of failure to respond to other first line opioid medications. The clinical documentation submitted for review does not provide any evidence that the injured worker requires additional medication beyond what is currently being prescribed. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request cannot be determined. The request for MS Contin 30 mg, thirty count, is not medically necessary or appropriate.

IMITREX 100 MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) HEAD CHAPTER, TRIPTANS.

Decision rationale: The California Medical Treatment Utilization Schedule does not address this type of medication. Official Disability Guidelines recommend that this medication is primarily used to manage symptoms related to chronic migraine headaches. There was no clinical documentation submitted to support this request. There is no documentation that the injured worker suffers from chronic migraine headaches and requires pharmacological management. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request cannot be determined. The request for Imitrex 100 mg, thirty count, is not medically necessary or appropriate.

RELPAK 40 MG #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE:[HTTP://WWW.RXLIST.COM/RELPAK-DRUG/INDICATIONS-DOSAGE.HTM](http://www.rxlist.com/relpax-drug/indications-dosage.htm).

Decision rationale: The California Medical Treatment Utilization Schedule and Official Disability Guidelines do not address this request. An online resource, Rxlist.com indicates that this medication is primarily used for the pharmacological management of migraine headaches. There was no clinical documentation to support this request. There was no documentation of a

diagnosis of chiropractic migraine headaches. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. The request for Relpax 40 mg, thirty count, is not medically necessary or appropriate.

DENDRACIN TOPICAL CREAM: 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 clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration of time. The California Medical Treatment Utilization Schedule does not support the use of topical nonsteroidal anti-inflammatory drugs for treatment durations to exceed four weeks. The clinical documentation does indicate that the injured worker has using this medication for longer than four weeks. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not clearly identify a dose/frequency of treatment, or appropriate body part. In the absence of this information, the appropriateness of the request itself cannot be determined. The request for Dendracin topical cream is not medically necessary or appropriate.