

Case Number:	CM13-0068689		
Date Assigned:	01/03/2014	Date of Injury:	12/04/2003
Decision Date:	04/21/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/19/2013

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, has a subspecialty in Pain Medicine, and is licensed to practice in Texas. 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 patient is a 45-year-old who reported an injury on December 4, 2003. The patient reportedly suffered an onset of low back pain with radiation to bilateral lower extremities while pulling a trash can. The patient is currently diagnosed as status post lumbar fusion, cervical degenerative disc disease with fusion and disc replacement, and reactive depression. The patient was seen by [REDACTED] on October 23, 2013. The patient reported worsening pain in the lower back with radiation to the left lower extremity. Current medications include Norco, Ambien, Neurontin, Lyrica, tramadol, cyclobenzaprine, Butrans, Prevacid, Lidoderm, and Compazine. The patient also utilizes ThermoCare heat wraps. Physical examination revealed limited lumbar range of motion, positive straight leg raising, 5/5 motor strength in bilateral lower extremities, and absent knee and ankles reflexes on the left. Treatment recommendations at that time included ten sessions of psychotherapy, as well as continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325 MG, 240 COUNT WITH ONE REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report worsening pain. There is no change in the patient's physical examination that would indicate functional improvement. Satisfactory response to treatment has not been indicated. The request for Norco 10/325 mg, 240 count with one refill, is not medically necessary or appropriate.

MS CONTIN 15 MG, 60 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. According to the documentation submitted, there is no evidence of this patient's current or previous utilization of this medication. Therefore, the current request cannot be determined as medically appropriate. The request for MS Contin 15 mg, 60 count, is not medically necessary or appropriate.

NEURONTIN 800 MG, 240 COUNT WITH THREE REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. Neurontin has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. According to the documentation submitted, the patient has utilized this medication since 2012. Despite ongoing use, the patient continues to report persistent pain with radiation to the left lower extremity. Satisfactory response to treatment has not been indicated. It is additionally noted that the patient also currently utilizes Lyrica. The request for Neurontin 800 mg, 240 count with three refills, is not medically necessary or appropriate.

LIDODERM, 90 COUNT WITH FIVE REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. Lidocaine is indicated for neuropathic pain or localized peripheral pain after there has been evidence of a trial of first-line therapy. According to the documentation submitted, the patient has utilized this medication since 2012. However, the patient continues to report persistent pain with radiation. Despite ongoing use, the patient continues to report persistent pain. There is also no evidence of a failure to respond to first-line therapy. The request for Lidoderm, 90 count with five refills, is not medically necessary or appropriate.

THERMACARE LARGE, 30 COUNT WITH FIVE REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The Low Back Complaints Chapter of the ACOEM Practice Guidelines state at-home local applications of heat and cold are as effective as those performed by therapists. According to the clinical documentation submitted, the patient has continuously utilized ThermaCare wraps since 2012. Despite ongoing use, the patient continues to report worsening pain. The medical necessity for the ongoing use has not been established. There is also no mention of a contraindication to at-home local applications of heat as opposed to a heat wrap. The request for ThermaCare large, 30 count with five refills, is not medically necessary or appropriate.

COMPAZINE 10 MG, 90 COUNT WITH THREE REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation U.S. National Library of Medicine. U.S. Department of Health and Human Services National Institutes of Health

Decision rationale: Compazine is used to control severe nausea and vomiting, as well as to treat schizophrenia. Compazine tablets are also used on a short-term basis to treat anxiety. As per the documentation submitted, the patient does not present with complaints of anxiety, nausea, or vomiting. The patient does not maintain a diagnosis of schizophrenia. The medical necessity for

the ongoing use of this medication has not been established. The request for Compazine 10 mg, 90 count with three refills, is not medically necessary or appropriate.

LANSOPRAZOLE 30 MG, 30 COUNT WITH THREE REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAIDs (non-steroidal anti-inflammatory drugs). There is no indication of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. The request for Lansoprazole 30 mg, 30 count with three refills, is not medically necessary or appropriate.

TRAMADOL 200 MG, 30 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. According to the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report worsening pain. There is no change in the patient's physical examination that would indicate functional improvement. Satisfactory response to treatment has not been indicated. The request for Tramadol 200 mg, 30 count, is not medically necessary or appropriate.

CYCLOBENZAPRINE 10 MG, 90 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than two to three weeks. According to the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report worsening pain. There is no evidence of palpable muscle spasm or spasticity upon physical examination. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. The request for Cyclobenzaprine 10 mg, 90 count, is not medically necessary or appropriate.