MAXIMUS Federal Services

Case Number:	CM14-0003154		
Date Assigned:	01/31/2014	Date of Injury:	07/12/1981
Decision Date:	06/19/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/09/2014

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 Anesthesiology has a subspecialty in Pain Medicine and is licensed to practice in Georgia. 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 claimant is a 56-year-old male presenting with chronic pain following a work-related injury on July 12, 1981. The claimant complains of low back pain that was present most of the time and radiating to both buttocks and legs and feet with the left being greater than the right, right shoulder pain that was constant and exacerbated by cold weather with pain radiation to the right arm and elbow, mid and upper back pain that was constant, right hand and wrist pain radiating to the right elbow and finally occasional neck pain. On October 28, 2013 the claimant complains of pain in the low back. The physical exam revealed tenderness from the mid to distal lumbar segments and pain with terminal motion, positive seated nerve root test, dysesthesia of the L5 and S1 dermatomes. MRI of the lumbar spine revealed no scoliosis, multiple disc disease, L1-2 to 3 mm posterior disc protrusion, L2-3 3-4 mm posterior disc protrusion, choreiform millimeter anterior disc protrusion, L3-4-3 to 4 mm posterior disc protrusion, 5-6 mm anterior disc protrusion, L4-5 45 mm posterior disc protrusion, L5-S1 4-5 mm posterior disc protrusion, 3-4 mm anterior disc protrusion. The claimant was diagnosed with lumbar discopathy and electrodiagnostic evidence of right chronic L5 radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL HYDROCHLORIDE ER 150 MG QUANTITY 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids Page(s): 79.

Decision rationale: Tramadol HCL ER 150mg # 90 is not medically necessary. Tramadol is a centrally- acting opioid. Per Chronic Pain Medical Treatment Guidelines page 83, opioids for osteoarthritis is recommended for short-term use after failure of first line non-pharmacologic and medication option including Acetaminophen and NSAIDS. Additionally, Page 79 of Per Chronic Pain Medical Treatment Guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the claimant continued to report pain. Given Tramadol is a synthetic opioid, it's use in this case is not medically necessary. The claimant has long-term use with this medication and there was a lack of improved function or return to work with this opioid and all other medications. Therefore the request is not medically necessary and appropriate.

NAPROXEN SODIUM 550 MG QUANTITY 100: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, (NSAIDS) non-steroidal anti-inflammatory drugs Pa.

Decision rationale: Naproxen Sodium 550mg # 100 is not medically necessary. Per Chronic Pain Medical Treatment Guidelines page 67, NSAIDS are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain so to prevent or lower the risk of complications associate with cardiovascular disease and gastrointestinal distress. The medical records do no document the length of time the claimant has been on Naproxen. Additionally, the claimant had previous use of NSAIDs; therefore the request is not medically necessary and appropriate.

CYCLOBENZAPRINE HYDROCHLORIDE 7.5 MG QUANTITY 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Anti-Spasmodics. Page(s): 64.

Decision rationale: Cyclobenzaprine HCL 7.5mg # 120 is is not medically necessary for the client's chronic medical condition. The peer-reviewed medical literature does not support long-term use of cyclobenzaprine in chronic pain management. Additionally, Per Chronic Pain

Medical Treatment Guidelines Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001). As per Chronic Pain Medical Treatment Guidelines, the addition of Cyclobenzaprine to other agents is not recommended. In regards to this claim, Cyclobenzaprine was prescribed for long term use and in combination with other medications. Cyclobenzaprine is therefore, not medically necessary and appropriate.

TEROCIN PATCHES QUANTITY 10: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Anagelsic Page(s): 111-112.

Decision rationale: According to Chronic Pain Medical Treatment Guidelines, 2009, chronic pain, page 111 Chronic Pain Medical Treatment Guidelines does not cover "topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended, is not recommended". Additionally, Chronic Pain Medical Treatment Guidelines page 111 states that topical analgesics such as lidocaine are " recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (anti-depressants or AED)...Only FDA-approved products are currently recommended. Non-neuropathic pain: Not recommended. The claimant was not diagnosed with neuropathic pain and there is no documentation of physical findings or diagnostic imaging confirming the diagnosis. Per Chronic Pain Medical Treatment Guidelines topical analgesic such as Lidocaine is not recommended for non-neuropathic pain. Therefore the request is not medically necessary and appropriate.