

Case Number:	CM14-0009488		
Date Assigned:	05/02/2014	Date of Injury:	10/31/2011
Decision Date:	07/24/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	01/24/2014

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 Neurological Surgery 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 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 43-year-old female injured on October 31, 2011. Also noted, was a prior request for epidural steroid injections to the lower lumbar spine. A pain management consultation completed in November, 2013 noted ongoing complaints of low back pain and difficulty performing activities of daily living. The physical examination noted no acute distress. The examination was within normal limits, tendon reflexes were noted to be 2+ in the upper extremities and there was a decreased lumbar spine range of motion. There was tenderness to palpation across the lower lumbar spine. Straight leg raising was noted to be 70 bilaterally. Previous imaging studies noted a disc protrusion. Multiple previous monthly follow-up evaluations are noted, the clinical findings are essentially unchanged.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO HYDROCODONE-ACET DATE OF SERVICE 10/01/213: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

Decision rationale: This medication has been employed for a number of months and there is no noted efficacy or utility with this preparation. As outlined in the MTUS Chronic Pain Guidelines, this is indicated when demonstrated utility is noted. Furthermore, there is no noted opioid contract or urine drug screening to support that appropriate utilization of this medication is being employed. Therefore, based on a clinical information presented for review, there is insufficient data to support this request. The request is not medically necessary and appropriate.

TRAMADOL HCI 200MG DATE OF SERVICE 10/01/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Page(s): 80.

Decision rationale: This is a synthetic opioid which can be useful for treatment of musculoskeletal pain. However, based on the numerous medical records presented for review, there is no improvement in functionality, activities of daily living or ability to return to work. Furthermore, the multiple progress notes do not establish there is any efficacy with the continued use of this opioid preparation under the MTUS Chronic Pain Guidelines. There is no indication this has been used in conjunction with other narcotic medications, and there is no noted improvement in activities of living or levels of pain complaints offered. As such, the request is not medically necessary and appropriate.

SOLARAZE 3% GEL DATE OF SERVICES 10/01/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: This is a topical preparation of a non-steroidal anti-inflammatory medication that is not indicated for soft tissue myofascial injuries secondary to its increased risk profile. Given the noted potential complications tempered by the fact that there has not been any significant improvement, there is no clinical indication presented to support the ongoing use of this preparation under the MTUS Chronic Pain Guidelines. As such, the request is not medically necessary and appropriate.

MEDROX PATCH DATE OF SERVICE 10/01/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

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

Decision rationale: Medrox ointment is a topical analgesic ointment containing Methyl Salicylate 20.00%, Menthol 5.00%, Capsaicin 0.0375%. The MTUS Chronic Pain Guidelines notes that topical analgesics are largely experimental and there have been few randomized controlled trials. Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Based on the clinical documentation provided, there is no documentation that a previous trial of oral antidepressant or anticonvulsant has been attempted. As such, in accordance with the MTUS Chronic Pain Guidelines, the request is not medically necessary and appropriate.

METAXALONE 800MG DATE OF SERVICE 10/01/13: Upheld

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

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

Decision rationale: Medrox ointment is a topical analgesic ointment containing Methyl Salicylate 20.00%, Menthol 5.00%, Capsaicin 0.0375%. The MTUS Chronic Pain Guidelines notes that topical analgesics are largely experimental and there have been few randomized controlled trials. Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Based on the clinical documentation provided, there is no documentation that a previous trial of oral antidepressant or anticonvulsant has been attempted. As such, in accordance with the MTUS Chronic Pain Guidelines, the request is not medically necessary and appropriate.

HYDROCODONE ACET DATE OF SERVICE 11/01/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Page(s): 80.

Decision rationale: This is an individual with a long history of a soft tissue myofascial strain of the lumbar spine and noted degenerative disc disease. This medication has been employed for a number of months and there is no noted efficacy or utility with this preparation as outlined in the MTUS Chronic Pain Guidelines. Furthermore, there is no noted opioid contract or urine drug screening to support that appropriate utilization of this medication is being employed. Therefore, based on a clinical information presented for review, the request is not medically necessary and appropriate.

TRAMADOL HCL ER 200MG DATE OF SERVICE 11/01/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

Decision rationale: This is a synthetic opioid which can be useful for treatment of musculoskeletal pain. However, based on the numerous medical records presented for review, there is no improvement in functionality, activities of daily living or ability to return to work as outlined in the MTUS Chronic Pain Guidelines. Furthermore, the multiple progress notes do not establish that there is any efficacy with the continued use of this opioid preparation. There is no indication this has been used in conjunction with other narcotic medications, and there is no noted improvement in activities of living or levels of pain complaints offered. As such, the request is not medically necessary and appropriate.

SOLARAZE 3% GEL DATE OF SERVICE 11/01/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

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

Decision rationale: This is a topical preparation of a non-steroidal anti-inflammatory medication that is not indicated for soft tissue myofascial injuries secondary to its increased risk profile. Given the noted potential complications tempered by the fact that there has not been any significant improvement, there is no clinical indication presented to support the ongoing use of this preparation under the MTUS Chronic Pain Guidelines. As such, the request is not medically necessary and appropriate.

MEDROX PATCH DATE OF SERVICE 11/01/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111/127.

Decision rationale: Medrox ointment is a topical analgesic ointment containing Methyl Salicylate 20.00%, Menthol 5.00%, Capsaicin 0.0375%. The MTUS Chronic Pain Guidelines notes that topical analgesics are largely experimental and there have been few randomized controlled trials. Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Based on the clinical documentation provided, there is no documentation that a previous trial of oral antidepressant or anticonvulsant has been attempted. As such, the request is not medically necessary and appropriate.

METAXALONE 800MG DATE OF SERVICE 11/01/13: Upheld

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

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

Decision rationale: As outlined in the MTUS Chronic Pain Guidelines, the use of muscle relaxant type medications is limited to the short term use to address acute flares. There is no indication for a chronic, indefinite use of this type of medication. Furthermore, the progress notes do not indicate any noted efficacy, utility, improvement with the noted muscle spasms or functional improvement/activities of daily living as a result of this medication. Therefore, there is insufficient clinical data presented to support this request. The request is not medically necessary and appropriate.