

Case Number:	CM14-0104607		
Date Assigned:	07/30/2014	Date of Injury:	06/15/2000
Decision Date:	09/22/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/07/2014

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 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 56-year-old male, who reported an injury on 06/15/2000. The mechanism of injury is not provided. On June 30, 2014, the injured worker presented with neck and low back pain. He also reported poor sleep quality due to pain. A CT of the lumbar spine dated October 26, 2011 reported diffuse degenerative changes and degenerative disc disease. There was a posterior and anterior fusion at the T11-12, facet sclerosis, and mild disc bulge of 1 mm at the T12-L1. Medications included Cymbalta, Fentora, Miralax, morphine, Valium, Sumavel, and Prilosec. Upon examination, the injured worker had antalgic gait and occiput tenderness. He ambulated with the use of a cane. There was ongoing baseline axial low back pain with ongoing T level pain and hardware pain. The diagnoses were displacement of the lumbar disc without myelopathy, cervical/cranial syndrome, degenerative intervertebral disc, lumbago, thoracic/lumbosacral neuritis/radiculitis, degenerative lumbar lumbosacral intervertebral disc, cervicgia, unspecified myalgia and myositis, spasm of the muscle, and post laminectomy syndrome of the lumbar region. The provider recommended diclofenac sodium, tramadol, quazepam, Norco, levofloxacin, Menthoderm gel, and Terocin patches. The provider's rationale was not provided. The Request for Authorization form was not included in medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac Sodium ER 100 mg 120 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 70.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state all NSAIDs are associated with risk of cardiovascular events, include MI, stroke, and onset or worsening of pre-existing hypertension. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with individual treatment goals. The injured worker rated his average pain since last visit as 10/10 and functional level since last visit a 9/10. There is lack of documentation that the injured worker is having a positive response to the medication. There is lack of documentation of increased function and decreased pain. As such, the request for Diclofenac Sodium ER 100 mg 120 count is not medically necessary or appropriate.

Tramadol ER 150 mg, ninety count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation or risk for aberrant drug abuse behavior, and side effects. The efficacy of the prior use of the medication has not been provided. As such, the request for Tramadol ER 150 mg, ninety count, is not medically necessary or appropriate.

Quazepam: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The Chronic Pain Medical Treatment Guidelines do not recommend the use of benzodiazepines for long term use because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to four weeks. The provider's request does not indicate the dose, quantity, or frequency of the medication in the request as submitted. Additionally, the efficacy of the prior use of the medication has not been provided. As such, the request for Quazepam is not medically necessary or appropriate.

Norco 10/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation or risk for aberrant drug abuse behavior, and side effects. The efficacy of the prior use of the medication has not been provided. The request for Norco 10/325 mg is not medically necessary or appropriate.

Levofloxacin 750 mg, quantity of thirty: 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 Other Medical Treatment Guideline or Medical Evidence: RxList, Levaquin, Online Database.www.RxList.com/Levaquin.

Decision rationale: Scientific based research states Levaquin or levofloxacin is used to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. Levaquin is also indicated for treatment of nosocomial pneumonia or community acquired pneumonia due to methicillin susceptible staphylococcus aureus. There were no signs and symptoms or diagnosis related to an infection in the provided medical documentation. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. The request for levofloxacin 750 mg with a quantity of thirty is not medically necessary or appropriate.

Menthoderm Gel: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that topical compounds are largely experimental in use with few randomized control trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of

antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines state that Lidoderm is the only topical form of lidocaine approved. Included medical documentation lacked evidence of a failed trial of an antidepressant or anticonvulsant. Additionally, as the guidelines recommend Lidoderm as the only topical formulation of lidocaine, the medication would not be warranted. The provider's request does indicate the site that the medication is indicated for, the dose, or the frequency in the request as submitted. The request for Methoderm gel is not medically necessary or appropriate.

Terocin Patch, thirty count, is not medically necessary and appropriate.: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that topical compounds are largely experimental in use with few randomized control trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines state that Lidoderm is the only topical form of lidocaine approved. Included medical documentation lacked evidence of a failed trial of an antidepressant or anticonvulsant. Additionally, as the guidelines recommend Lidoderm as the only topical formulation of lidocaine, the medication would not be warranted. The provider's request does indicate the site that the medication is indicated for, the dose, or the frequency in the request as submitted. The request for Terocin Patch, thirty count, is not medically necessary or appropriate.