

Case Number:	CM14-0018973		
Date Assigned:	04/23/2014	Date of Injury:	08/30/2005
Decision Date:	07/09/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/14/2014

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 & Rehabilitation 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 patient is a 53 year-old male who has filed a claim for cervical sprain, lumbar myoligamentous injury, and traumatic brain injury associated with an industrial injury date of August 30, 2005. Review of progress notes low back pain radiating to the left lower extremity, neck pain radiating down to both upper extremities. There has been an increase in reported pain levels from 5 to 8/10. Findings include an antalgic gait favoring the left lower extremity, tenderness with muscle rigidity of the cervical and lumbar regions, numerous trigger points throughout the cervical and lumbar paraspinal musculature, and decreased cervical and lumbar range of motion. There is decreased sensation in bilaterally along the C5 to 6 distributions, and the left L5 distribution. Straight leg raise test is positive on the left, and deep tendon reflexes are decreased in the left lower extremity. EMG of the upper extremities performed in May 2010 showed bilateral C6 radiculopathy, left greater than the right. Cervical MRI showed disk protrusions at C4-5 and C5- 6 causing some mild left and central neural foraminal stenosis. EMG of the lower extremities performed in September 2009 showed mild bilateral L5 radiculopathy. Lumbar MRI showed multi-level disk protrusions. Treatment to date has included NSAID, opioids, Soma, Lidoderm patch, Dendracin cream, and epidural injections. Utilization review from February 03, 2014 denied the request for Duragesic 50mg and Norco 10/325mg as there is no documentation of measurable analgesic benefit or functional benefits with the use of this medication; Lidoderm patch as there is no documentation of failure of oral agents used for neuropathic pain; Soma 350mg as this medication is only supported for short-term use; Anaprox DS 550 mg at documentation does not report significant benefit with the use of this medication; and AndroGel as there is no documentation of low testosterone levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

DURAGESIC 50MG, Q. 2. D. (EVERY 2 DAYS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ON-GOING REVIEW AND DOCUMENTATION OF PAIN RELIEF.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44,78-81.

Decision rationale: As noted on page 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Duragesic is at fentanyl transdermal therapeutic system. As noted in page 44 of CA MTUS chronic pain medical treatment guidelines, Duragesic is indicated in management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. Patient has been on this medication since at least April 2013. In this case, there is no documentation regarding objective functional benefits derived from this medication. Patient's pain level has increased from 5 to 8 out of 10 while on this medication. Also, the requested quantity is not specified. Therefore, the request for Duragesic 50mg was not medically necessary.

NORCO 10/325MG, #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS- CRITERIA FOR USE Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: As noted on page 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since at least April 2013. Patient currently takes up to 6 tablets of Norco per day. Progress note reports that patient was started on OxyContin 20mg per day in order to decrease the amount of Norco to 1-2 tablets per day. There is documentation of periodic urine drug screens consistent with medication use. This is a reasonable amount of Norco tablets to allow down titration of this medication. Therefore, the request for Norco 10/325mg #60 was medically necessary.

LIDODERM PATCH 1 Q.D. PRN (ONE EVERYDAY AS NEEDED): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

Decision rationale: As stated on pages 56-57 in the CA MTUS chronic pain medical treatment guidelines, Lidoderm may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. Patient has been on this medication since at least April 2013. In this case, there is no documentation of localized pain, or that the patient has tried and failed first-line therapy. Also, the requested quantity is not specified. Therefore, the request for Lidoderm 5% was not medically necessary.

SOMA 350MG 4 Q.D. (4 TIMES A DAY): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS FOR PAIN.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29 AND 65.

Decision rationale: Pages 29 and 65 of CA MTUS Chronic Pain Medical Treatment Guidelines state that Soma is not recommended. Carisoprodol is metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. Patient has been on this medication since at least April 2013. This medication is not recommended for long-term use. The patient is on opioids for which combination with Soma can produce serious adverse effects. Also, the requested quantity is not specified. Therefore, the request for Soma 350mg was not medically necessary.

ANAPROX DS 550MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (NON-STEROIDAL ANTI-INFLAMMATORY DRUGS) Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-69.

Decision rationale: As stated in pages 67-69 of the California MTUS chronic pain medical treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. In this case, patient has been on this medication since at least April 2013. There is no documentation regarding objective benefits derived from this medication. Also, patient is already on opioid therapy and there is no rationale for continued use of NSAIDs. The requested quantity is not specified. Therefore, the request for Anaprox DS 550mg was not medically necessary.

ANDROGEL 1.62%, 2-4 PUMPS PER DAY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 110-111.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines states that testosterone replacement for hypogonadism (related to opioids) is recommended in limited circumstances for patients taking high-dose long-term opioids with documented low testosterone levels. In this case, patient has been on Androderm patch since at least April 2013, and on Androgel since July 2013. However, there is no documentation submitted regarding blood tests assessing testosterone levels. Therefore, the request for Androgel 1.62% was not medically necessary.

