

Case Number:	CM14-0155050		
Date Assigned:	09/25/2014	Date of Injury:	09/08/2011
Decision Date:	11/14/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/22/2014

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 Management 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:

According to the records made available for review, this is a 44-year-old male with a 9/8/11 date of injury. At the time (8/25/14) of request for authorization for retro Cyclobenzaprine 7.5mg #60, retro Topiramate 25mg #60, retro Menthoderm 120mg #1, and retro Tramadol 50mg PO up to TID PRN #90, there is documentation of subjective (burning low back pain radiating to left leg) and objective (tenderness over lumbar spine with spasm and restricted lumbar range of motion) findings, current diagnoses (lumbar strain and sciatica), and treatment to date (medications (including ongoing treatment with Menthoderm cream, Topiramate, Cyclobenzaprine since at least 5/12/14, and Tramadol)). Regarding retro Cyclobenzaprine 7.5mg #60, there is no documentation of acute exacerbation of chronic low back pain; the intention for short-term (less than two weeks) treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Cyclobenzaprine use to date. Regarding retro Topiramate 25mg #60, there is no documentation that anticonvulsants have failed; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Topiramate use to date. Regarding retro Menthoderm 120mg #1, there is no documentation that trial of antidepressants and anticonvulsants have failed; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Menthoderm cream use to date. Regarding retro Tramadol 50mg PO up to TID PRN #90, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; moderate to severe pain; and functional

benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Tramadol use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Cyclobenzaprine 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle Relaxants (for Pain), Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Flexeril is recommended for a short course of therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of lumbar strain and sciatica. However, despite documentation of muscle spasm, there is no documentation of acute muscle spasm, or acute exacerbation of chronic low back pain. In addition, given documentation of records reflecting prescriptions for Flexeril since at least 5/12/14, there is no documentation of the intention for short-term (less than two weeks) treatment. Furthermore, given documentation of ongoing treatment with Cyclobenzaprine, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Cyclobenzaprine use to date. Therefore, based on guidelines and a review of the evidence, the request for Retro Cyclobenzaprine 7.5mg #60 is not medically necessary.

Retro Topiramate 25mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate (Topamax) Page(s): 21. Decision based on Non-MTUS Citation Topiramate (Topamax)

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when other anticonvulsants have failed, as criteria necessary to support the medical necessity of Topiramate. MTUS-Definitions identifies that any treatment

intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar strain and sciatica. In addition, there is documentation of neuropathic pain; and ongoing treatment with Topiramate. However, there is no documentation that anticonvulsants have failed. In addition, given documentation of ongoing treatment with Topiramate, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Topiramate use to date. Therefore, based on guidelines and a review of the evidence, the request for Retro Topiramate 25mg #60 is not medically necessary.

Retro Mentoderm 120mg #1: 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): 111-112. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/cdi/mentoderm-cream.html>, and Title 8, California Code of Regulations, section 9792.20.

Decision rationale: Medical Treatment Guideline identifies Mentoderm cream as a topical analgesic containing Methyl Salicylate and Menthol. MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when trial of antidepressants and anticonvulsants have failed, as criteria necessary to support the medical necessity of topical analgesics. Within the medical information available for review, there is documentation of diagnoses of lumbar strain and sciatica. In addition, there is documentation of neuropathic pain; and ongoing treatment with Mentoderm cream. However, there is no documentation that trial of antidepressants and anticonvulsants have failed. In addition, given documentation of ongoing treatment with Mentoderm cream, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Mentoderm cream use to date. Therefore, based on guidelines and a review of the evidence, the request for retro Mentoderm 120mg #1 is not medically necessary.

Retro Tramadol 50mg PO up to TID PRN #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram; Ultram ER; generic available) Page(s): 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80; 113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the

lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; as criteria necessary to support the medical necessity of opioids. In addition, specifically regarding Tramadol, MTUS Chronic Pain Medical Treatment Guideline identifies documentation of moderate to severe pain and Tramadol used as a second-line treatment (alone or in combination with first-line drugs), as criteria necessary to support the medical necessity of Tramadol. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar strain and sciatica. In addition, there is documentation of ongoing treatment with Tramadol; and Tramadol used as a second-line treatment. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, despite documentation of pain, there is no (clear) documentation moderate to severe pain. Furthermore, given documentation of ongoing treatment with Tramadol, there is no documentation functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Tramadol use to date. Therefore, based on guidelines and a review of the evidence, the request for Retro Tramadol 50mg PO up to TID PRN #90 is not medically necessary.