

Case Number:	CM14-0028114		
Date Assigned:	06/25/2014	Date of Injury:	02/29/2008
Decision Date:	11/21/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	03/05/2014

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 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 53-year-old male who reported an injury on 02/29/2008. The mechanism of injury occurred while he was pushing a cart and twisted his back. The injured worker's diagnosis included low back pain. The past treatments included physical therapy. There was no official diagnostic imaging submitted for review. There was no relevant surgical history documented in the records. The subjective complaints on 06/14/2013 included low back pain that radiates to the right lower extremity, rated 10/10, and is worse with walking. The objective physical exam findings noted dorso-lumbar pain and tenderness with spasms with limitation to flexion and extension. There was also sacroiliac joint tenderness present on the left. The deep tendon reflexes are rated 2+ and symmetrical. It was also noted that the patient has low back pain that is radiating to the right lower extremity in the S1 distribution and appears to have recurrent lumbar radiculopathy. The injured worker's medications included Lyrica 50 mg, Tylenol Extra Strength, Robaxin 500 mg, Ultram 50 mg, Lexapro 20 mg, Tramadol 50 mg, Percocet 10/650 mg, Seroquel 50 mg, Clonazepam 1 mg, and Norco 10/325 mg. The notes indicate that the patient has been on the aforementioned medications since at least 03/14/2013. The treatment plan was to continue the medications. A request was received for (Methocarbamol) Robaxin 500 mg, (Tadalafil) Cialis 20 mg, Hydrocodone/Acetaminophen, Norco 10/325, and Diclofenac sodium, Voltaren gel 1%. The rationale for the request was not provided in the clinical notes. The Request for Authorization form was not provided in the records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methocarbamol (Robaxin) 500mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

Decision rationale: The request for (Methocarbamol) Robaxin 500 mg is not medically necessary. The California MTUS Guidelines state that muscle relaxants for pain are recommended as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. The notes indicate that the injured worker has been on Robaxin since at least 03/14/2013. As the guidelines recommend Robaxin for short term use, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Tadalafil (Cialis) 20mg: 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: RX List.com, Dosage and indications, <http://www.rxlist.com/cialis-drug/indications-dosage.htm>

Decision rationale: The request for (Tadalafil) Cialis 20 mg is not medically necessary. The California MTUS/ACOEM Guidelines did not address. The RX List indications for Cialis are as follows: Cialis is indicated for treatment of erectile dysfunction and signs and symptoms of benign prostatic hyperplasia. There is a lack of documentation in the clinical notes that the patient has erectile dysfunction or benign prostatic hyperplasia. In the absence of the above documentation, the request is not supported. As such, the request is not medically necessary.

Hydrocodone/Acetaminophen (Norco) 10/325mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request for Hydrocodone/Acetaminophen (Norco) 10/325 mg is not medically necessary. The California MTUS Guidelines state 4 domains that have been proposed as the most relevant for monitoring of chronic pain patients on opioids. These include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant or non-adherent drug related behaviors. The injured worker has chronic pain. There was

not adequate documentation in the clinical notes submitted of quantified numerical pain relief, side effects, physical and psychosocial functioning or aberrant behavior. Furthermore, there was no current drug screen submitted to assess for aberrant behavior. Additionally, the request submitted did not provide a medication frequency. As adequate documentation was not submitted of quantified numerical pain relief, side effects, physical and psychosocial functioning, and aberrant behavior, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Diclofenac Sodium (Voltaren Gel) 1%: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request for Diclofenac sodium, Voltaren gel 1% is not medically necessary. The California MTUS Guidelines state that Voltaren gel% is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment such as ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of spine, hip, or shoulder. As the injured worker has chronic low back pain and Voltaren gel is not recommended for the spine, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.