MAXIMUS Federal Services

Case Number:	CM14-0034179		
Date Assigned:	06/20/2014	Date of Injury:	06/14/2000
Decision Date:	12/15/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	03/19/2014

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, has a subspecialty in Pain Medicine 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 46-year-old male who reported an injury on 06/14/2000. The mechanism of injury was not provided. His diagnoses were noted to include status post left knee surgery, left knee recurrent internal derangement, right knee sprain/strain, lumbar discogenic disease with radiculitis, chronic cervical spine sprain/strain, cervical discogenic disease, cervical facet syndrome, and status post multiple inguinal hernia repairs on the left side. His past treatments were noted to include medication and a TENS unit. He is status post left knee surgery and status post multiple inguinal hernia repairs on the left side. During the assessment on 12/19/2013, the injured worker complained of chronic low back, neck, right wrist, and left knee pain. The physical examination of the cervical spine revealed spasm and decreased range of motion. There was facet tenderness and radiculopathy bilaterally at C5-7. The physical examination of the right wrist revealed a positive Phalen's and Durkan compression. The physical examination of the lumbar spine revealed spasm with painful and limited range of motion. It also revealed positive Lasegue's bilaterally, positive straight leg raise bilaterally, with motor weakness bilaterally. There was pain bilaterally at the S1 distribution. The physical examination of the left knee revealed tenderness to palpation over the joint line. His medications were noted to include Norco 10/325 mg, Anaprox DS, LkG caps cream, and Flexeril. The treatment plan was to continue with medication and a TENS unit. The rationale for Norco 10/325 mg, Anaprox d2, Flexeril, and LkG caps cream was to assist with pain. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, on-going management Page(s): 78.

Decision rationale: The request for Norco 10/325 mg is not medically necessary. The California MTUS Guidelines state that the ongoing management of opioid use should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines specify that an adequate pain assessment should include the current pain level; the least reported pain over the period since the last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Additionally, there was no quantified information regarding pain relief, including a detailed assessment with the current pain on a VAS, average pain, intensity of pain, or longevity of pain relief. Furthermore, there was a lack of documentation regarding adverse effects and evidence of consistent results on urine drug screens to verify appropriate medication use. Additionally, the frequency and quantity were not included with the request. In the absence of this documentation, the ongoing use of Norco 10/325 mg is not supported by the guidelines. As such, the request is not medically necessary.

Anaprox DS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: The request for Anaprox DS is not medically necessary. The California MTUS Guidelines indicate that there is consistent evidence for the use of NSAIDs to treat long term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis with neuropathic pain. The use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. There was no clinical documentation provided that the injured worker complained of any breakthrough or acute pain. There was no clinical documentation provided that the injured worker had tried acetaminophen prior to using NSAIDs and had an inadequate response. Furthermore, the dose, frequency, and quantity were not provided within the request. Due to the lack of pertinent information, the ongoing use of Anaprox DS is not medically necessary.

Flexeril: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) and Antispasmodics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: The request for Flexeril is not medically necessary. The California MTUS Guidelines recommend cyclobenzaprine as an option, using a short course of therapy. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement and low back pain and is associated with drowsiness and dizziness. Treatment should be brief. There was no quantified information regarding pain relief, including a detailed assessment with the current pain on a VAS, average pain, intensity of pain, or longevity of pain relief. Additionally, the dose, frequency, and quantity were not provided. Given the above, the request is not supported by the guidelines and is therefore not medically necessary.

LkG Caps Cream: 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): 111-113.

Decision rationale: The request for LkG caps cream is not medically necessary. The California MTUS Guidelines state that topical analgesics 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. The guidelines also state that any compounded product that contains at least 1 drug that is not recommended, is also not recommended. There was a lack of adequate documentation regarding a failure of antidepressants and anticonvulsants. The request did not specify the drug contents in the compound, making it difficult to determine if the compound contains 1 or more drugs that are not recommended by the guidelines. Additionally, the application site for the proposed medication was also not provided. Given the above, the request for LkG caps cream is not medically necessary.