

Case Number:	CM14-0039084		
Date Assigned:	06/27/2014	Date of Injury:	08/08/2003
Decision Date:	08/14/2014	UR Denial Date:	03/31/2014
Priority:	Standard	Application Received:	04/03/2014

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 Interventional Spine 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 57-year-old female with an 8/08/2003 date of injury. She has been diagnosed with nonunion C5-6, status-post (s/p) revision 5/17/12, s/p posterior revision 7/22/13; C6-7 fusion; acute cervical strain; right shoulder impingement; spondylolisthesis L4/5 with sacral slope (SS); spondylolisthesis L3/4; degenerative disc disease (DDD) L3-S1, rule out (r/o) acute lumbar herniated nucleus pulposus (HNP). According to the 3/24/14 orthopedic report from [REDACTED], the patient presents with unchanged severe low back pain, 8/10 radiating to the lower left extremity (LLE) with weakness and numbness. She had a cervical surgery on 7/22/13 and has not returned to work. [REDACTED] dispensed Anaprox, Fexmid, Ultram, Protonix, and Methoderm. On 3/31/14, UR denied the medications. On 4/7/14, [REDACTED] appealed the UR decision stating he was in accordance with MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox DS/Naproxen 550mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory Medications Page(s): 22.

Decision rationale: According to the 3/24/14 orthopedic report from [REDACTED], the patient presents with unchanged severe low back pain, 8/10 radiating to the lower left extremity (LLE) with weakness and numbness. The IMR request is for use of Anaprox DS/naproxen 550 mg. There were only two reports provided for this IMR, the 3/24/14 report and the 4/7/14 appeal. It is not known how long the patient had been on the medications in question. The 3/24/14 report states the patient needed refills of the medications, which suggests that she has been using the Anaprox since the last visit with the physician. The 3/24/13 report states the pain is the same, and there is no discussion of efficacy of any of the medication. MTUS on page 9 states All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement MTUS page 8 states: When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There is no reporting on efficacy of the medications, the documentation does not support a satisfactory response. There is no mention of improved pain, or improved function or improved quality of life with the use of Naproxen. MTUS does not recommend continuing treatment if there is not a satisfactory response. Therefore, the request is not medically necessary.

Fexmid/Cyclobenzaprine 7.5mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: According to the 3/24/14 orthopedic report from [REDACTED], the patient presents with unchanged severe low back pain, 8/10 radiating to the lower left extremity (LLE) with weakness and numbness. The IMR request is for use of Fexmid/cyclobenzaprine 7.5mg. . There were only two reports provided for this IMR, the 3/24/14 report and the 4/7/14 appeal. It is not known how long the patient had been on the medications in question. The 3/24/14 report states the patient needed refills of the medications, which suggests that she has been using the cyclobenzaprine since the last visit. The report shows that #60 tablets of 7.5mg Cyclobenzaprine was dispensed at 3/day. This is a 20-day/3-week supply, and the physician notes it is a refill. MTUS guidelines for cyclobenzaprine specifically state this is not recommended for use over 2-3 weeks. The current refill is for the maximum recommended duration of cyclobenzaprine, so when combined with the prior prescription it exceeds MTUS recommendations. Recommendation is not medically necessary.

Ultram/Tramadol HCL ER 150mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 8-9, 75, 88-89, 113.

Decision rationale: According to the 3/24/14 orthopedic report from [REDACTED], the patient presents with unchanged severe low back pain, 8/10 radiating to the lower left extremity (LLE) with weakness and numbness. The IMR request is for use of Ultram/tramadol HCL ER 150mg. There were only two reports provided for this IMR, the 3/24/14 report and the 4/7/14 appeal. It is not known how long the patient had been on the medications in question. The 3/24/14 report states the patient needed refills of the medications, which suggests that she has been using the Ultram/tramadol HCL ER 150mg since the last visit. The 3/24/13 report states the pain is the same, and there is no discussion of efficacy of any of the medication. MTUS on page 9 states All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement MTUS page 8 states: When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There is no reporting on efficacy of the medications on either the 3/24/14 report or the 4/7/14 appeal. The documentation does not support a satisfactory response. There is no mention of improved pain, or improved function or improved quality of life with the use of Ultram/tramadol HCL ER 150mg. MTUS does not recommend continuing treatment if there is not a satisfactory response. Recommend not for medical necessity.

Protonix/Pantoprazole 20mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

Decision rationale: According to the 3/24/14 orthopedic report from [REDACTED], the patient presents with unchanged severe low back pain, 8/10 radiating to the lower left extremity (LLE) with weakness and numbness. The IMR request is for use of Protonix/pantoprazole 20mg. There were only two reports provided for this IMR, the 3/24/14 report and the 4/7/14 appeal. The 3/24/14 report does not discuss dyspepsia from NSAID to support use of Protonix for treatment, nor does it discuss any of the risk factors for gastrointestinal (GI) events that the patient might have to support the use of Protonix on a prophylactic basis. The 4/7/14 appeal confirms efficacy of Protonix, for these conditions listed above, but does not provide any indication that the patient has any of the risk factors that allow use for prophylaxis or if the patient has any current GI condition that would allow for use of Protonix as treatment. None of the reports state whether the patient has GERD, heartburn, or ulcer, or if any of the medications cause dyspepsia. The use of Protonix without documentation of rationale is not in accordance with MTUS guidelines. Recommendation is not medically necessary.

Menthoderm 120ml: 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): 105, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Biofreeze.

Decision rationale: According to the 3/24/14 orthopedic report from [REDACTED], the patient presents with unchanged severe low back pain, 8/10 radiating to the lower left extremity (LLE) with weakness and numbness. The IMR request is for use of Methoderm. Methoderm gel contains Methyl salicylate 15.00% and Menthol 10.00%. On page 111, under topical analgesics, MTUS gives a general statement about compounded products: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS has support for methyl salicylate under the Topical Salicylate section, but does not specifically discuss menthol. The Official Disability Guidelines (ODG) were consulted. ODG guidelines state the active ingredient in Biofreeze is menthol and that it is recommended for acute pain and take the place of an ice pack for cryotherapy. In this case, the patient, who was injured over 10 years ago, is not in the acute phase, and the use of menthol for a chronic condition is not in accordance with the ODG recommendations. Menthol would not be recommended for a chronic condition, so the whole compounded product that contains Menthol, is not recommended. Recommend not medically necessary.