

Case Number:	CM14-0040245		
Date Assigned:	08/01/2014	Date of Injury:	10/22/1999
Decision Date:	09/11/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/07/2014

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 and Pain Management and is licensed to practice in Florida. 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 51-year-old male who reported an injury on 10/22/1999. The mechanism of injury was not provided for review. The injured worker's treatment history included the development of chronic pain managed by multiple medications to include Gralise, Zomig, Baclofen, Fortesta, Zanaflex, Dexilant, methadone, Dilaudid, Duexis, Flexeril and Subsys. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker's diagnoses included post-laminectomy syndrome of the cervical spine, cervicogenic headache, cervicocranial syndrome, brachial neuritis/radiculitis and muscle spasm. The injured worker was evaluated on 02/06/2014. It was noted that the injured worker was averaging 5 to 6 migraine headaches per month. It was noted that the injured worker's medications were described as providing fair benefit. Physical findings included left shoulder pain, occipital tenderness and tenderness to the left shoulder region. A request was made for a refill of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gralise 600mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epileptics Page(s): 16.

Decision rationale: The requested Gralise 600 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend anti-epileptics as first line medications in the management of chronic pain. However, a reduction of pain of at least 30% and documented functional benefit should be provided to support continued use. The clinical documentation indicates that the injured worker has been on this medication since at least 09/2013. However, the most recent clinical documentation does not provide any evidence of a quantitative assessment of pain reduction or functional benefit to support continued use. Furthermore, the request, as it is submitted does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Gralise 600 mg #90 is not medically necessary or appropriate.

Zomig #10: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Head Chapter, Triptans.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Chapter, Triptans.

Decision rationale: The requested Zomig #10 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address this medication. Official Disability Guidelines recommend triptans to assist with migraine headache management. The clinical documentation does indicate that the injured worker has 5 to 6 migraines per month. However, the intensity and duration of these migraine headaches was not provided. Therefore, the efficacy of this medication cannot be established. Furthermore, the request, as it is submitted, does not provide a dosage or frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Zomig #10 is not medically necessary or appropriate.

Baclofen 10mg, #90: 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 Muscle Relaxants Page(s): 63.

Decision rationale: The requested Baclofen 10 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends muscle relaxants for short durations of treatment for acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 09/2013. This exceeds guideline recommendations. Additionally, the clinical documentation fails to identify a quantitative assessment of pain relief or specific

functional benefit related to the use of medication. Furthermore, the request, as it is submitted, does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Baclofen 10 mg #90 is not medically necessary or appropriate.

Fortesta 2 pumps/day, #1 bottle: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com/Fortesta Gel.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Testosterone replacement for hypogonadism (related to opioids).

Decision rationale: The requested Fortesta 2 pumps per day #1 bottle is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this type of medication. Official Disability Guidelines recommend testosterone replacement in limited circumstances for injured workers who are on high doses of opioids for extended durations. The clinical documentation submitted for review does indicate that the injured worker has been taking multiple high doses of opioids for an extended duration. However, specific evidence of hypogonadism is not provided within the physical evaluation. Therefore, the need for this medication is not supported. As such, the requested Fortesta 2 pumps per day #1 bottle is not medically necessary or appropriate.

Zanaflex 4mg, #60: 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 Muscle Relaxants Page(s): 63.

Decision rationale: The requested Zanaflex 4 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends muscle relaxants for short durations of treatment for acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 09/2013. This exceeds guideline recommendations. Additionally, the clinical documentation fails to identify a quantitative assessment of pain relief or specific functional benefit related to the use of medication. Furthermore, the request, as it is submitted, does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Zanaflex 4 mg #60 is not medically necessary or appropriate.

Dexilant 60mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested Dexilant 60 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for injured workers who are at risk for developing gastrointestinal symptoms related to medication usage. The clinical documentation does not provide an adequate assessment of the injured worker's gastrointestinal system to support the ongoing use of a gastrointestinal protectant. Furthermore, the request, as it is submitted, does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Dexilant 60 mg #90 is not medically necessary or appropriate.

Methadone 10mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Use for Chronic Pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 63.

Decision rationale: The requested methadone 10 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, managed side effects, functional benefit and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior with urine drug screen. However, a quantitative assessment of pain relief and specific documentation of functional benefit was not provided. Furthermore, the request, as it is submitted, does not provide a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested methadone 10 mg #90 is not medically necessary or appropriate.

Dilaudid 4mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Use for Chronic Pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 63.

Decision rationale: The requested Dilaudid 4 mg #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing use of opioids in the management of chronic pain be supported by a quantitative assessment of pain

relief, managed side effects, functional benefit and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior with urine drug screen. However, a quantitative assessment of pain relief and specific documentation of functional benefit was not provided. Furthermore, the request, as it is submitted, does not provide a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Dilaudid 4 mg #120 is not medically necessary or appropriate.

Flexeril 10mg, #60: 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 Muscle Relaxants Page(s): 63.

Decision rationale: The requested Flexeril 10 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends muscle relaxants for short durations of treatment for acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 09/2013. This exceeds guideline recommendations. Additionally, the clinical documentation fails to identify a quantitative assessment of pain relief or specific functional benefit related to the use of medication. Furthermore, the request, as it is submitted, does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Flexeril 10 mg #60 is not medically necessary or appropriate.

Abstral 400ugm, #32: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Use for Chronic Pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 63.

Decision rationale: The requested Abstral 400 ugm #32 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, managed side effects, functional benefit and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior with urine drug screen. However, a quantitative assessment of pain relief and specific documentation of functional benefit was not provided. Furthermore, the request, as it is submitted, does not provide a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Abstral 400 ugm #32 is not medically necessary or appropriate.

Lorzone (to consider): 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 Muscle Relaxants Page(s): 63.

Decision rationale: The requested Lorzone is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the short term usage of muscle relaxants in the management of acute exacerbations of chronic pain. The clinical documentation submitted for review does not provide any evidence that the injured worker suffers from an acute exacerbation of chronic pain that would benefit from the use of muscle relaxants. Additionally, the request, as it is submitted, does not clearly identify a dosage, frequency of treatment or quantity. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Lorzone is not medically necessary or appropriate.