

Case Number:	CM14-0045214		
Date Assigned:	06/27/2014	Date of Injury:	05/10/1992
Decision Date:	08/21/2014	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	04/01/2014

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:

The patient is a 52-year-old female with a 5/10/92 date of injury. 11/4/13 progress note described 65% reduction of pain with functional improvement since the last ESI (Epidural Steroid Injection). The patient was utilizing Hydrocodone 10/500 q.i.d. (four times a day); Gabapentin 300 mg, 1-4 per day; Tramadol 50 mg, 2-3 per day; and Robaxin 500 mg, 2 per day. Treatment plan discussed continuing medications. 12/9/13 note described prior ESI, and pending trigger point injections. Medications remained the same and were refilled. 1/27/14 progress note described severe ongoing low back pain with radiation into the lower extremities, below the knees. The patient has attempted multiple pain medication treatments with medications, and continues to attend psychiatric sessions. Currently she is utilizing multiple pain medications, including Hydrocodone, Gabapentin, Tramadol, and Robaxin. Clinically, there was reduced range of motion lumbar spine with tenderness, positive SLR (straight-leg-raising) bilaterally, and moderate/severe tenderness over the sacrococcygeal junction and left piriformis muscle. The patient had mild/moderate SI (Sacroiliac) joint tenderness bilaterally. Diagnosis includes lumbar strain/sprain; lumbar radiculopathy; sacroiliitis; and myofasciitis. Refill of medications was requested. 3/17/14 Pain management follow-up described reduction of pain from 9/10 to 4-5/10 with medications, as well as improvement of functional abilities and ADLs (Activities of Daily Living). Without medications functional ability is essentially 0. Treatment to date has included ESI, trigger point injections, activity modification, psychiatric treatment, and medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/500mg #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81.

Decision rationale: Medical necessity for the requested hydrocodone 10/500 mg, #120 is established. This request was partially certified in order to allow for weaning. There was a lack of documentation regarding continued analgesia, continued functional benefit, a lack of adverse side effects, or aberrant behavior, as required by CA MTUS. Within the context of this appeal, an additional note was provided, describing significant pain improvement with the current medication regimen, from 9/10 pain levels to 4-5/10. The patient is unable to function at all without medications. As the patient obtains substantial pain relief and improvement with ADLs (Activities of Daily Living) and as the MED (Minimal Effective Dose) is relatively low, the request is substantiated. Therefore, the request of Hydrocodone 10/500mg #120 is medically necessary and appropriate.

Gabapentin 300mg #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines Page(s): 16-22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16-17.

Decision rationale: Medical necessity for the requested Gabapentin is established. This request previously obtained an adverse determination, as it was not entirely clear what functional benefit the patient obtained from the prescribed medication regimen. However, within the context of this appeal, it was noted that the current pain medication regimen provides pain relief from 9/10 to 4-5/10 with improvement in ADLs (Activities of Daily Living). The patient has low back pain with radiation to lower extremities, and CA MTUS Guidelines states that Gabapentin is considered as a first-line treatment for neuropathic pain. Therefore, the request of Gabapentin 300mg #120 is medically necessary and appropriate.

Tramadol 50mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol (Ultram) Page(s): 82.

Decision rationale: Medical necessity for the requested Tramadol is established. Guidelines do not recommend Tramadol as a first line treatment option; however when there is ongoing chronic

pain, documented functional improvement, and reduction in pain, continued use may be indicated. Within the context of this appeal, it was noted that there is significant functional improvement with the current medication regimen. Without medications, the patient is unable to be functional, and is mostly home bound. With the prescribed medications, pain levels reduce from 9/10-4-5/10. In combination with the requested Norco, the MED (Minimal Effective Dose) remains within guidelines recommendations. Therefore, the request of Tramadol 50mg #90 is medically necessary and appropriate.

Robaxin 500mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines Page(s): 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants/Antispasmodics and Antispasticity drugs Page(s): 63.

Decision rationale: In regards to Robaxin 500mg, this request is not found medically reasonable. The patient has been utilizing this muscle relaxant for some time; however there is no discussion describing specific functional improvement from the requested muscle relaxant, and reduction in spasms. There is a lack of guideline support for chronic use of muscle relaxants, as efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. There is no discussion regarding an acute exacerbation, requiring the short-term use of a muscle relaxant. Therefore, the request of Robaxin 500mg #60 is not medically necessary and appropriate.