MAXIMUS Federal Services

Case Number:	CM14-0085011		
Date Assigned:	07/23/2014	Date of Injury:	08/06/2002
Decision Date:	10/17/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/06/2014

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 Nevada. 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 records presented for review indicate that this 60 year-old male was reportedly injured on August 6, 2002. The most recent progress note, dated May 2, 2014, indicates that there were ongoing complaints of low back pain. The physical examination demonstrated an alert and oriented individual, in no acute distress. Deep tendon reflexes of the lower extremities are decreased bilaterally, 1+. The patient's gait is antalgic, favoring the left side. There is tenderness to palpation over the lumbar paraspinal muscles, the facet joints, and the SI joints, with exquisite tenderness over the hardware on the left, as well as trigger points noted over the lower paraspinal muscles. Range of motion in the lumbar spine is normal other than flexion which is limited to 40 with pain, and extension which is limited to 10 without pain. There is reversal of the normal lumbar lordosis. Straight leg raise test was negative. The patient had normal motor strength and muscle tone to the bilateral lower extremities. Diagnostic imaging studies were not included for review. Previous treatment includes L4-L5 discectomy and fusion in 2005, exercise, physical therapy, heat, epidural steroid injection, stretching, and medications. Requests have been made for Voltaren 1% topical gel (30/days with two refills), Meloxicam 15 mg (#30 with two refills), hydrocodone/APAP 10/325 mg (#180 with two refills), Mirtazapine 15 mg (#30 with two refills), Cyclobenzaprine 10 mg (#30 with two refills) and were not certified in the pre-authorization process on May 28, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% topical gel 30/days, with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 111-112 of 127..

Decision rationale: MTUS guidelines support the topical Diclofenac for the relief of osteoarthritic pain of the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. Outside of the treatment of osteoarthritis, there is no other clinical indication for the use of this topical non-steroidal anti-inflammatory. The claimant suffers from low back pain. As such, there is no indication for this medication and the request is not considered medically necessary.

Meloxicam 15mg, # 30, with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 72 of 127..

Decision rationale: This medication is a type of non-steroidal anti-inflammatory medication, which are the traditional first-line treatment to reduce pain selectivity and functional restoration can resume, but long-term use may not be warranted. However, when noting the date of the injury and the minimal documentation demonstrating improvement functionality and/or pain, there is no clear clinical indication for continued use of this medication. Additionally, meloxicam is indicated for osteoarthritis. Use for mild to moderate pain is off label. As such, the request is not considered medically necessary.

Hydrocodone/APAP 10/325mg, # 180 with 2 refills:

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 74-78, 88, 91 of 127..

Decision rationale: As noted in the MTUS, this is for the short-term management of moderate to severe breakthrough pain. Furthermore, as outlined in the MTUS, the treatment plan parameters outlined in the MTUS for chronic opioid use require noting if the diagnosis has changed, other medications are being employed, or if any attempt has been made to establish the efficacy of the medications with documentation of functional improvement. Furthermore, adverse effects have to be addressed. None of these parameters to continue this medication chronically have been measured. Therefore, the medical necessity is not established.

Miritazapine 15mg, # 30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 13 of 127..

Decision rationale: Remeron (Mirtazapine) is a tetracyclic anti-depressant used in the treatment of Major Depressive Disorder and other mood disorders. The MTUS guidelines recommend tricyclic antidepressant medications as a first-line option in the treatment of neuropathic pain and in some clinical settings for non-neuropathic pain when there is underlying depression. The claimant is being treated for low back pain with radicular symptoms, as well as depression. A more appropriate option would be treatment with a tricyclic antidepressant, or an SNRI. However, there is no documentation indicating that the claimant has failed the recommended first-line medication, and while it is noted that this medication should not be abruptly stopped, it is not medically necessary.

Cyclobenzaprine 10mg, # 30, with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Muscle relaxants Page(s): 41, 64.

Decision rationale: MTUS Guidelines support the use of skeletal muscle relaxants for the short-term treatment of pain, but advises against long-term use. Given the claimant's date of injury and clinical presentation, the guidelines do not support this request for chronic pain. As such, the request is not medically necessary.