

Case Number:	CM14-0091893		
Date Assigned:	07/25/2014	Date of Injury:	02/04/2009
Decision Date:	10/31/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/17/2014

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 64-year-old female who reported injury on 02/04/2009. The mechanism of injury was not submitted for review. The injured worker has diagnoses of low back pain with right lower extremity radiculopathy, evidence of moderate bilateral foraminal stenosis L3, L4 to L5 and L5 to L6 with bilateral facet degenerative changes, and a large 8 x 9 mm central disc extrusion at L1 to L2 with moderate central canal stenosis. Past medical treatment consisted of surgery, physical therapy, lumbar epidural steroid injections, and medication therapy. Medications include fentanyl patch, hydrocodone, gabapentin, omeprazole, TRICOR, Diovan, metformin, and Xanax. The injured worker has undergone post lumbar decompressive surgery in 08/2009, and a lap band procedure in 06/2011. On 05/05/2014, the injured worker complained of low back pain. The physical examination had noted that the injured worker rated her pain at a 5/10 with medication and 9/10 without. It was noted on low back examination that the injured worker had moderate bilateral paraspinous tenderness with 1+ palpable muscle spasm. Range of motion had flexion of 25 degrees, extension of 5 degrees, right lateral flexion of 10 degrees, and left lateral flexion of 10 degrees. The injured worker had a positive straight leg raise on the right at 45 degrees. Muscle testing revealed 5/5 bilaterally. Sensory examination revealed hypesthesia in the right L5 dermatome. The medical treatment plan is for the injured worker to continue the use of medication therapy. The rationale and Request for Authorization Form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 12mcg/hour one every 48 hours.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl) ongoing management, opioid dosing, Page(s): 44, 78, 86.

Decision rationale: The request for fentanyl patch is not medically necessary. The California MTUS Guidelines indicate that Duragesic (fentanyl) is not recommended as a first line therapy. The FDA approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the patient is being monitored for aberrant drug behavior and side effects. The submitted documentation lacked any evidence of side effects the injured worker might have had with the medication. There was also lack of evidence that the fentanyl was helping with any functional deficits the injured worker had or the efficacy of the medication. The report does submit a drug screen dated 02/06/2014, showing that the injured worker was compliant with the MTUS Guidelines, but there was no documentation of any objective improvement in function. Furthermore, the request as submitted did not provide a frequency of the medication. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Hydrocodone 2.5/108 mg per 15 ml once daily to two times daily, 90 ml.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management, Hydrocodone/Acetaminophen, Page(s): 78, 91.

Decision rationale: The request for hydrocodone is not medically necessary. The California MTUS Guidelines state that hydrocodone is indicated for moderate to moderately severe pain, and there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. An assessment should include a pain level before, during, and after medication administration. The documentation submitted for review did not indicate the efficacy of the medication. There was also no indication that the medication was helping with any functional deficits. A drug screen submitted on 02/06/2014 showed that the injured worker was in compliance with her medications. However, there was no assessment showing what pain levels were before, during, and after medication administration. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Gabapentin 300 mcg/6 ml, 470 ml.: Upheld

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

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

Decision rationale: The request for gabapentin is not medically necessary. The California MTUS Guidelines indicate that gabapentin is shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered as a first line treatment for neuropathic pain. There was no evidence in the submitted documentation of the injured worker having a diagnosis of diabetic neuropathy or postherpetic neuralgia. After initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. The documentation submitted for review indicated that the injured worker has been prescribed gabapentin since at least 05/2014. The efficacy of the medication was not submitted for review. The provider's rationale was not provided. The medical documentation did not indicate that the injured worker had significant difficulties taking traditional tablet medications, which would indicate the injured worker's need for oral suspension medication. Furthermore, the request as submitted did not indicate a frequency or duration of the medication. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Trial Keto/Gaba/Lido cream, 240 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The request for keto/gaba/lido cream is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesia is primarily indicated for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compound that contains at least 1 drug that is not recommended is not recommended. The guidelines note muscle relaxants are not recommended for topical application. The guidelines note gabapentin is not recommended for topical application. Topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. It is recommended for short term use (4 to 6 weeks). As the guidelines do not recommend the use of muscle relaxants or gabapentin for topical application, the medication would not be indicated. It is also unclear if the injured worker had a diagnosis which would be congruent with the guideline recommendations for topical NSAIDs. As such, the request is not medically necessary.