

Case Number:	CM15-0002117		
Date Assigned:	01/13/2015	Date of Injury:	11/27/2006
Decision Date:	03/16/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 41 year old male who sustained an industrial injury on 11/27/2006. He has reported lower back pain with radiation bilaterally to the lower extremities, numbness in the left leg, and foot drag on the left. The diagnoses have included mechanical low back pain, discogenic low back pain, and degenerative joint disease of the lumbar spine. According to an evaluation on 10/ 11/ 2013, treatment to that date had included pain medication, TENS Unit, nerve blocks and surgery that were felt by the IW to improve his condition. Massage and exercise were felt to have no change in the condition, and the IW described the physical therapy as having worsened his condition. Currently, according to the primary treating physician's progress report (PR-2) of 07/24/2014 the IW complains of low back pain with radiation to both legs rated a 3/10 on the right, and with foot drag on the left. Pain is 6/10 with numbness when weight is sustained on the left side. The IW related that Gralise has helped with the numbness, and pain is tolerable with medication. Objectively the IW transfers with stiffness and guarding. There was more sensitivity to touch on the right side than on the left. Legs have normal strength. There was tenderness to palpation in the lumbar region. On 12/09/2014 Utilization Review non-certified a request for Butrans 20mcg #4, noting the there was no documentation of objective functional improvement that would support the subjective benefit noted and failure to respond to a time -limited course of opioids leads to the suggestion of reassessment and consideration of alternative therapy. California Medical Treatment Utilization Schedule (CA MTUS) Chronic pain Opioids was referenced. On 12/09/2014 Utilization Review non-certified a request for Robaxin 500mg #120, noting the there was no documentation of muscle spasm or exacerbation

of the low back pain. Both CA MTUS and ODG state that muscle relaxants are recommended for short term usage. Prior reviews had warned that the claimant should wean from this medication. CA MTUS Muscle Relaxants (for pain), and Official Disability Guide-Treatment in Worker's Compensation (ODG-TWC) Muscle relaxants were cited. On 12/09/2014 Utilization Review non-certified Robaxin 500mg #120 noting anti-convulsant agents (AED's) are recommended for neuropathic pain (pain due to nerve damage). Although the current medication regimen was subjectively reported to decrease pain scores and allow the claimant to be functional, there was no supportive evidence of objective functional improvement or progressive return to work. Without evidence of objective functional benefit with prior medication use and due to non-compliance with medication guidelines, medical necessity was not supported. CA MTUS Anti-epilepsy drugs (AEDs) was cited. On 01/05/2015 a request for an independent medical review of the decisions to non-certify Butrans 20mcg #4, Robaxin 500mg #120 and Robaxin 500mg #120 was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Butrans 20mcg #4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

Decision rationale: Regarding the request for Butrans, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is pain relief noted, but there is no indication that the medication is improving the patient's function (in terms of specific examples of functional improvement) and there is no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Butrans is not medically necessary.

Robaxin 500mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), ODG-TWC, Muscle relaxants

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

Decision rationale: Regarding the request for Robaxin, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Robaxin is not medically necessary.

Gralise 600mg #60: 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 Antiepilepsy Drugs Page(s): 16-21.

Decision rationale: Regarding request for Gralise, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that 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. Within the documentation available for review, while there is some improved numbness noted, this is not quantified and there is no identification of any specific objective functional improvement. In the absence of such documentation, the currently requested Gralise is not medically necessary.