

Case Number:	CM15-0137416		
Date Assigned:	07/27/2015	Date of Injury:	06/13/2004
Decision Date:	10/06/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/15/2015

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: Preventive Medicine, Occupational Medicine

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 56-year-old male who sustained an industrial injury on June 13, 2004. He has reported low back pain with lower extremity radiation and has been diagnosed with lumbar sprain with right lower extremity radiculopathy, facet arthropathy, and sacroiliac sprain with referred pain to the right thigh and lower extremity. Treatment has included medications, therapy, surgery, and injection. He did have low back pain, mainly right lumbosacral increasing with extension and increasing with forward flexion. He has tenderness about the cervical occipital and neck muscles. He had numbness in the right hand thumb, index, and radial side. The low back had tenderness in the right lumbosacral, increasing somewhat with forward flexion to touch his mid-thigh and increasing with extension 10 degrees. He had pain guarding with respect to his low back. There was tenderness and tight muscle, right anterior lateral thigh and numbness and discomfort down into the foot somewhat laterally, but also a great toe component. Straight leg raise on the right was positive at 80 degrees. The treatment request includes cyclobenzaprine, gabapentin, lidocaine, Voltaren gel, hydrocodone, massage therapy, and a pain management consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 10mg Qty: 60 plus 2 refills: 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 Page(s): 64.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants such as cyclobenzaprine. The patient has been taking cyclobenzaprine for an extended period, long past the 2-3 weeks recommended by the MTUS. The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. Cyclobenzaprine 10mg Qty: 60 plus 2 refills is not medically necessary.

Gabapentin 300mg Qty: 90 with 1 refill: 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 9792.20-9792.26 Page(s): 19.

Decision rationale: The MTUS states that gabapentin is an anti-epilepsy drug, which has been 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. An adequate trial period for gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. With each office visit the patient should be asked if there has been a change in the patient's pain symptoms, with the recommended change being at least 30%. There is no documentation of any functional improvement. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly. Gabapentin 300mg Qty: 90 with 1 refill is not medically necessary.

Hydrocodone-acetaminophen 10/325mg Qty: 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use for a therapeutic trial of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Hydrocodone-acetaminophen, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. Hydrocodone-acetaminophen 10/325mg Qty: 120 is not medically necessary.

Massage therapy for low back Qty: 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792. 20-9792. 26 Page(s): 60.

Decision rationale: According to the MTUS, massage therapy can be recommended as an option when limited to 4-6 visits and as an adjunct to other recommended treatments, specifically, an exercise regimen. The benefits of massage therapy at her only during treatment and treatment tendons should be avoided. The short-term benefits of massage therapy or likely due to the fact that massage does not address the underlying causes of pain. There is no documentation that the patient is participating in an exercise program as required by the MTUS. Massage therapy for low back Qty: 6 is not medically necessary.

Pain management consult: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Harris J. Occupational Medicine Practice Guidelines 2nd edition (2004) pp. 289-291.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment, 04/27/2007, pg. 56.

Decision rationale: The California MTUS makes no recommendations regarding referral to a pain management specialist. Alternative guidelines have been referenced. The guidelines state that referral to a pain specialist should be considered when the pain persists but the underlying tissue pathology is minimal or absent and correlation between the original injury and the severity of impairment is not clear. Consider consultation if suffering and pain behaviors are present and the patient continues to request medication, or when standard treatment measures have not been successful or are not indicated. Pain management consult is not medically necessary.

Lidocaine 5% external patch, Qty: 30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792. 20-9792. 26 Page(s): 112.

Decision rationale: The MTUS recommends lidocaine patches only for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Lidocaine is currently not recommended for a non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. Lidocaine 5% external patch, Qty: 30 with 1 refill is not medically necessary.

Voltaren gel 1% transdermal gel Qty: 1 plus 2 refills: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Voltaren® Gel (diclofenac).

Decision rationale: According to the Official Disability Guidelines, Voltaren gel is not recommended as a first as a first-line treatment, and is recommended only for osteoarthritis after failure of oral NSAIDs, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. Documentation in the medical record does not meet guideline criteria. Voltaren gel 1% transdermal gel Qty: 1 plus 2 refills is not medically necessary.