MAXIMUS Federal Services

Case Number:	CM15-0210813		
Date Assigned:	10/29/2015	Date of Injury:	09/10/2014
Decision Date:	12/10/2015	UR Denial Date:	10/15/2015
Priority:	Standard	Application Received:	10/27/2015

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: Connecticut, California, Virginia
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:

This is a 78 year old male who sustained a work-related injury on 9-10-14. Medical record documentation on 9-21-15 revealed the injured worker was being treated for continuous opioid dependence and displacement of lumbar intervertebral disc without myelopathy. He reported pain in the bilateral shoulders, right arm, right elbow, right wrist, right hand, mid back, low back, right leg and feet. His pain was associated with numbness and tingling of the right hand and right foot and with weakness in the feet. He described his pain as constant and severe. The pain was rated a 7 on a 10-point scale with 6 on a 10-point scale at best and 9 on a 10-point scale at worst. His average pain level in the previous 7 days was 7 on a 10-point scale. His pain was relieved with lying down, medications and relaxation. His neck pain was 70% of his pain, and the arm pain was 50% of the pain. The pain in his back was 30% of the pain and the pain in his leg was 90% of the pain. He avoided going to work, socializing with friends, exercise, household chores, recreational activities, driving, yard work, sexual relations and caring for himself due to pain. Objective findings included a normal gait pattern without assistive device. He had normal alignment with mild loss of lumbar lordosis. He had tenderness to palpation over the right lumbar paraspinal muscles and positive facet loading maneuver bilaterally. He had negative straight leg raise bilaterally in a seated position to 50 degrees. A request for Menthoderm 15% analgesic gel 120 ml and hydrocodone 10-325 mg #60 was received on 10-1-15. On 10-15-15, the Utilization Review physician determined Menthoderm 15% analgesic gel 120 ml and hydrocodone 10-325 mg #60 was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Menthoderm 15% analgesic gel 120ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The MTUS guidelines on Topical Analgesics describe topical treatment as an option; however, topicals are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The MTUS states specifically that any compound product that contains at least one drug (or class) that is not recommended is not recommended. The lack of evidence to support use of topical compounds like the one requested coupled with the lack of evidence for functional improvement in this patient's clinical picture with chronic use makes the requested treatment not medically necessary.

Hydrocodone 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, specific drug list, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, long-term assessment, Opioids, pain treatment agreement, Opioids, specific drug list, Opioids, steps to avoid misuse/addiction.

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. Utilization Review reasonably denied the request as appropriate weaning has been previously suggested. Given the lack of clear evidence to support functional improvement on the medication and the chronic risk of continued treatment, the request for hydrocodone is not medically necessary.