

Case Number:	CM14-0145943		
Date Assigned:	09/12/2014	Date of Injury:	06/14/2000
Decision Date:	10/16/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/08/2014

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 and Pain Medicine and is licensed to practice in Texas and Ohio. 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 69-year-old male who reported an injury on 06/14/2000. The mechanism of injury was not submitted for review. The injured worker has diagnoses of post lumbar laminectomy syndrome, disc disorder of the lumbar spine, lumbar radiculopathy, and low back pain. Past medical treatment consists of physical therapy, transforaminal epidural steroid injection, aquatic therapy, and medication therapy. Medications consist of trazodone, Duragesic, Norco, Voltaren, Singulair, Spiriva, Symbicort, Androgel, aspirin, Ritalin tab, metoprolol, and pravastatin sodium. On 11/12/1984, the injured worker had a posterior spinal fusion at L4-5. On 01/30/2000, the injured worker underwent a CT discogram which revealed positive pain response at L2-3 and L3-4. On 10/01/2013, the injured worker underwent a UA showing that the injured worker was in compliance with his prescription medications. On 08/27/2014, the injured worker complained of back pain. Physical examination noted that the injured worker's pain rate was a 5/10 with medication and a 10/10 without. Examination of the lumbar spine revealed loss of normal lordosis with straightening of the lumbar spine and surgical scars. Range of motion was restricted with flexion limited to 50 degrees, extension limited to 10 degrees, right lateral bending limited to 20 degrees, left lateral bending limited to 20 degrees, lateral rotation to the left limited to 25 degrees, lateral rotation to the right limited to 30 degrees, and limited by pain. On palpation, paravertebral muscles revealed tenderness and tight muscle band bilaterally. No spinal process tenderness was noted. Lumbar facet loading was positive bilaterally. Tenderness was also noted over the sacroiliac spine. Upon sensory examination, light touch sensation was decreased over the L4, L5-S1 dermatome, significantly reduced on the right at level of lateral and medial calf and lateral foot on the right. The treatment plan was for the injured worker to continue use of medications. The provider feels medications are necessary for the injured worker

to maintain good pain management. The Request for Authorization form was submitted on 01/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Voltaren 1% Gel #3 DOS 07/25/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Chronic Pain, Topical Analgesics.

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

Decision rationale: The request for Retro Voltaren 1% Gel #3 DOS 07/25/14 is not medically necessary. California MTUS states Voltaren gel is an FDA approved agent indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 grams per day (8 grams per joint per day in the upper extremity and 16 grams per joint per day in the lower extremity). The submitted documentation did not indicate that the injured worker had a diagnosis of osteoarthritis. There was also no documentation showing evidence of pain in the joints. Additionally, the request as submitted did not indicate where the Voltaren gel would be applied. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Retro Duragesic 75mcg/hr patch #10 DOS 07/25/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Chronic Pain, Topical Analgesics.

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 Retro Duragesic 75mcg/hr. patch #10 DOS 07/25/14 is not medically necessary. California MTUS Guidelines indicate that Duragesic 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 cumulative dosing of all opiates should not exceed 120 mg oral morphine equivalents per day. The submitted documentation did not indicate the injured worker had trialed and failed any first line conservative treatment. Furthermore, the submitted documentation did not indicate the efficacy of the medication. It was not indicated that the Duragesic helped with any functional deficits the injured worker might have had. It was noted that urinalysis was submitted on 10/01/2013 showing that the injured worker was in compliance with his medications. However, there was no documented evidence showing any

objective improvement in function or objective decrease in pain. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Retro Trazodone 100mg #60 DOS 07/25/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Online Version, Pain Chapter, Insomnia Treatment

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (selective serotonin reuptake inhibitors), Trazodone. Page(s): 107.

Decision rationale: The request for Retro Trazodone 100mg #60 DOS 07/25/14 is not medically necessary. California MTUS Guidelines indicate that SSRIs are not recommended as a treatment for chronic pain, but Selective Serotonin Reuptake Inhibitors (SSRIs) may have a role in treating secondary depression. SSRIs have not been shown to be effective for low back pain. Given the above, the injured worker is not within the MTUS recommended guidelines. The submitted documentation did not indicate a diagnosis of secondary depression. Additionally, the efficacy of the medication was not submitted for review. As such, the request for Retro Trazodone 100mg #60 DOS 07/25/14 is not medically necessary.