

Case Number:	CM14-0075525		
Date Assigned:	07/16/2014	Date of Injury:	01/31/2013
Decision Date:	11/10/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	05/23/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 patient is a 36-year-old with a reported date of injury of 02/14/2009. The medical records were reviewed. The patient has the diagnoses of sleep disorder, lumbar degenerative disc disease, low back pain, lumbar post laminectomy syndrome, myalgia/myositis, cervical radiculopathy, spinal fusion, chronic pain syndrome, carpal tunnel syndrome, cervical degenerative disc disease, depression/anxiety, diabetes and headache. Per the most recent progress reports provided for review by the treating physician dated 06/05/2014, the patient had complaints of worsening back pain with radiation into the extremities. The physical exam noted antalgic gait with no other abnormalities documented. The treatment plan recommendations included trigger point injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 10 mg. #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-65.

Decision rationale: The long term chronic use of this medication is not recommended per the California MTUS Chronic Pain Medical Treatment Guidelines. The medication has not been prescribed for the acute flare up of chronic low back pain. The specific use of this medication for greater than 3 weeks is not recommended per the California MTUS. The criteria set forth above for its use has not been met. Therefore, the request is not medically necessary.

Etodolac 500 mg. #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 71-73.

Decision rationale: This medication is recommended at the lowest possible dose for the shortest period of time. The duration of "shortest period of time" is not defined in the California MTUS Chronic Pain Medical Treatment Guidelines. The patient has no mentioned cardiovascular, renovascular or gastrointestinal side-effects or risk factors. The dosage prescribed is within recommendations. Therefore, this request is medically necessary.

Lidocaine Pad 5% #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The requested medication is indicated for neuropathic pain. The patient does have the diagnosis of neuropathic pain. The patient also does have documentation of failure of medications of first line therapy choices and is currently on Gabapentin. For these reasons, criteria as set forth by the California MTUS Chronic Pain Medical Treatment Guidelines have been met for the use of this medication. Therefore, the request is medically necessary.

Tramadol Hydrochloride ER (Extend Release) 100 mg. #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-84.

Decision rationale: The long-term use of this medication is not recommended unless certain objective outcome measures have been met as defined in the MTUS Chronic Pain Medical Treatment Guidelines. There is no provided objective outcome measure that shows significant improvement in function while on the medication or a return to work. The most recent

documentation states the patient's pain is a 10/10 on the VAS scale without medication but fails to document a significant improvement in VAS score with the medication. The only improvement in function noted is the ability to get out of bed with the medication but not get dressed. For these reasons criteria for ongoing and continued use of the medication have not been met. Therefore, the request is not medically necessary.

Hydrocodone/APAP 10/325 mg. #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-84.

Decision rationale: The long-term use of this medication is not recommended unless certain objective outcome measures have been met as defined in the MTUS Chronic Pain Medical Treatment Guidelines. There is no provided objective outcome measure that shows significant improvement in function while on the medication or a return to work. The most recent documentation states the patient's pain is a 10/10 on the VAS scale without medication but fails to document a significant improvement in VAS score with the medication. The only improvement in function noted is the ability to get out of bed with the medication but not get dressed. For these reasons criteria for ongoing and continued use of the medication have not been met. Therefore, this request is not medically necessary.