

Case Number:	CM13-0015304		
Date Assigned:	05/14/2014	Date of Injury:	02/04/2009
Decision Date:	06/16/2014	UR Denial Date:	08/14/2013
Priority:	Standard	Application Received:	08/22/2013

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 has a subspecialty in Interventional Spine and is licensed to practice in California. 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 reported an injury on 2/4/09. Exam on 8/6/13 showed ambulation with significant antalgic gait. In low back, moderate bilateral paraspinous tenderness with 2+ palpable spasms. L-spine range of motion, flexion 20 degrees, extension 5 degrees, right lateral flexion 10 degrees, left lateral flexion 10 degrees. In lower extremities, positive straight leg raise exam on right at 40 degrees. Sensory: Hypoesthesia in right L5 dermatome. Patellar reflex is 2+ and symmetrical bilaterally. Achilles reflex is 1+ on right and 2+ on left. [REDACTED] is requesting Titrate liquid hydrocodone 7.5/325 mg Q6H as needed for severe breakthrough pain, liquid Neurontin 300mg 3 times a day (TID), Omeprazole 20mg RRN, Ambien 10mg QHS, Toradol injection into right gluteus provided on 7/23/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

TITRATE LIQUID HYDROCODONE 7.5/325MG Q6H AS NEEDED FOR SEVERE BREAKTHROUGH PAIN: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 76-78.

Decision rationale: This patient presents with persistent low back pain radiating to lower extremities bilateral primarily right lateral hip and thigh. Heaviness, numbness, tingling in both legs. Pain rated 8/10 with medication, 10/10 without. The physician has asked Titrade liquid hydrocodone 7.5/325 mg Q6H as needed for severe breakthrough pain on 8/6/13 due to patient's previous lap band procedure. On 3/9/13, patient is taking hydrocodone with reduction of pain and functional improvement in activities of daily living. On 6/11/13, patient continues to take hydrocodone without significant improvement in pain management or function. On 8/6/13, patient is counseled to reduce medicine dosage but reports inability to reduce. Patient has not shown drug seeking behavior and urine drug screen shows compliance. For chronic opioids use, MTUS guidelines require specific documentation regarding pain and function, including: least reported pain over period since last assessment; average pain; intensity of pain after taking opioid; how long it takes for pain relief; how long pain relief lasts. Furthermore, MTUS requires the 4 A's for ongoing monitoring including analgesia, activities of daily living (ADLs), adverse side effects, and aberrant drug-seeking behavior. In this case, the physician has asked for Titrade liquid hydrocodone 7.5/325 mg Q6H as needed for severe breakthrough pain, but does not include all required aspects of pain assessment. Patient has been taking liquid hydrocodone for 5 months without significant improvement in pain management or function, and a reduction or tapering in dosage has not been attempted. Therefore the requested titrade liquid hydrocodone is not medically necessary or appropriate.

LIQUID NEURONTIN 300MG THREE TIMES A DAY (TID): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin-Antiepilepsy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIEPILEPSY DRUGS (AEDS) Page(s): 16-18.

Decision rationale: The physician has asked Liquid Neurontin 300mg 3 times a day on 8/6/13 for neuropathic pain. The provider states that Liquid Neurontin is required secondary to previous Lap-Band surgery and lack of efficacy of crushed tablets. The patient did try crushed tablets for a 30-day period and did not find them effective. Patient is taking liquid Neurontin as of 2/28/13. On 7/5/13, physician states that due to the increase of radicular symptoms, her current medication regimen is providing approximately 10% improvement. On 8/6/13, patient reports 20% improvement of pain due to current medications. Regarding anti-convulsants, MTUS guidelines recommend for neuropathic pain, and necessitate documentation of improvement of function, side effects, and pain relief of at least 30% a lack of which would require: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. In this case, the physician has asked for Liquid Neurontin 300mg 3 times a day, but patient has had at least 5 months of usage without significant improvement, below the 30% threshold required by MTUS guidelines. Therefore, the requested Liquid Neurontin is not medically necessary or appropriate.

OMEPRAZOLE 20MG PRN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68-69.

Decision rationale: A review of the reports shows that Omeprazole is being prescribed as needed for gastrointestinal symptoms due to her opioid medication per the 5/30/13 report. Regarding Prilosec, MTUS does not recommend routine prophylactic use along with NSAID, and GI risk assessment must be provided. In this case, the physician has asked for Omeprazole 20mg PRN, but has not included GI risk assessment. Furthermore, MTUS guidelines do not approve use to counter side effects of opioid medication. Therefore, the requested Omeprazole is not medically necessary or appropriate.

AMBIEN 10MG QHS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC GUIDELINES, CHRONIC PAIN CHAPTER, INSOMNIA TREATMENT, FOR AMBIEN.

Decision rationale: The physician has asked for Ambien 10mg QHS on 8/6/13. Review of the reports shows patient has been taking Ambien since 2/28/13. On 5/30/13, patient is taking Ambien at bedtime as prescribed by family physician. As of 8/6/13, patient is still taking Ambien for over 5 months continuously. Regarding Ambien, ODG guidelines state that Ambien is recommended for short-term treatment (2 to 6 week period) of insomnia with difficulty of sleep onset (7-10 days). Not recommended for long-term use, as they can be habit-forming, and may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. In this case, the physician has requested Ambien 10mg QHS, but patient has been taking said medication for over a 5 month period, which exceeds ODG guidelines. Therefore, the requested Ambien is not medically necessary or appropriate.

TORADOL INJECTION INTO RIGHT GLUTEUS (DOD: 7/23/13): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketorolac (Toradol®), Generic Available) Page(s): 72.

Decision rationale: A review of the reports shows patient has had no prior Toradol injections. On 7/23/13, patient complained of excruciating back pain rated 10/10 even with medication due to a reinjury from removing groceries from the car on 7/20/13. The physician administered a

60mg Toradol injection intramuscularly to the right gluteus on 7/23/13 due to the patient's severe pain state and inability to tolerate oral anti-inflammatories due to history of Lap-Band procedure. Regarding Toradol, MTUS does not recommend it for minor or chronic pain conditions. ODG guidelines recommend it as an option to corticosteroid injections to shoulder, with up to three subacromial injections. In this case, the physician provided a Toradol injection into the right gluteus on 7/23/13, but patient has no documented symptoms of osteoarthritis. MTUS does not support it for chronic pain. Therefore, the Toradol provided on 7/23/13 was not medically necessary or appropriate.