

Case Number:	CM13-0034485		
Date Assigned:	12/18/2013	Date of Injury:	08/24/2004
Decision Date:	04/30/2014	UR Denial Date:	09/16/2013
Priority:	Standard	Application Received:	10/15/2013

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 59-year-old female with a reported date of injury on 08/24/2004; the mechanism of injury was a slip and fall. The clinical note dated 12/10/2013 noted the patient complained of intermittent low back pain with radiation down into the left leg, down the back of the thigh, and into the calf. The patient reported new onset of groin pain. The patient denied numbness and tingling. Upon physical exam, the patient had tenderness along the lumbar paraspinal muscles bilaterally. Lumbar flexion was 50 degrees, extension was 30 degrees and lateral tilting was 20 degrees on the left and 30 degrees on the right. The patient had diagnoses including chronic low back pain with radicular pain into the left leg in the L4 and L5 distributions and chronic lumbar pain due to the lumbar muscle tightness and muscle spasms. The patient reported that the pain level was a between 5-7/10 without medication and was 2/10 with.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG #120: Upheld

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

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

Decision rationale: The California MTUS guidelines state providers should conduct ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects in patients utilizing opioid medications. The guidelines note a pain assessment should be completed including the current pain level, the least reported pain over the period since the last assessment, average pain, and intensity of pain after the opioid and how long it takes for the pain relief and how long the pain relief lasts. The documentation provided for the Norco did not cover the 4 A's as recommended in the guidelines. The documentation provided did not include a full pain assessment as well as evidence of significant objective functional improvements. It was unclear when the patient last underwent a urine drug screen. Additionally, the request did not indicate the frequency at which the medication was prescribed in order to determine the necessity of the medication. Therefore, the request for the Norco is non-certified.

TRAMADOL ER 150MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 78-86.

Decision rationale: The California MTUS guidelines state providers should conduct ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects in patients utilizing opioid medications. The guidelines note a pain assessment should be completed including the current pain level, the least reported pain over the period since the last assessment, average pain, and intensity of pain after the opioid and how long it takes for the pain relief and how long the pain relief lasts. The documentation provided for the tramadol did not cover the 4 A's as recommended in the guidelines. The documentation provided did not include a full pain assessment, as well as evidence of significant objective functional improvements. It was unclear when the patient last underwent a urine drug screen. Additionally, the request did not indicate the frequency at which the medication was prescribed in order to determine the necessity of the medication. Therefore, the request for the tramadol is non-certified.

NEURONTIN 600MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NEURONTIN Page(s): 18-19.

Decision rationale: The California MTUS guidelines state gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered a first-line treatment for neuropathic pain. The documentation provided did not indicate that the patient had a diagnosis congruent with the recommended diagnoses within the guidelines. Within the provided documentation the requesting physician did not include adequate documentation of significant objective functional improvement with the medication.

Additionally, the request did not indicate the frequency at which the medication was prescribed in order to determine the necessity of the medication. Therefore, the request is non-certified.

ACETADRYL 25/500MG #50: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ACETAMINOPHEN Page(s): 11. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN

Decision rationale: Acetadryl is comprised of acetaminophen and diphenhydramine. The California MTUS guidelines recommend acetaminophen for the treatment of chronic pain and acute exacerbations of chronic pain. Diphenhydramine is covered in the Official Disability Guidelines, which state that for over-the-counter medications: sedating antihistamines have been suggested for sleep aids (for example, Diphenhydramine. The tolerance seems to develop within a few days for patients. Next day sedation has been noted, as well as impaired psychomotor and cognitive function. The requesting physician's rationale for the request was unclear. Within the provided documentation it was unclear if the patient had any complaints of insomnia or trouble sleeping, which would indicate the patients need for Acetadryl. Therefore, the request is non-certified.

PRILOSEC 20MG #60: Upheld

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

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

Decision rationale: The California MTUS recommends that you the provider proceed with cautions with NSAIDs and to review the patient's history of any gastrointestinal events or history of peptic ulcers, GI bleeding or perforation; the history of use of NSAIDs or any history of H. pylori. The guidelines state non-selective NSAIDs okay such as ibuprofen, naproxen, etc. and the guidelines recommend for patients with no risk factors and no cardiovascular disease. Within the provided documentation there was a lack of information demonstrating the patient was at risk for gastrointestinal events. The patient did not have a documented history of peptic ulcers, GI bleeding, or perforation. The requesting physician's rationale for the request was unclear. Therefore, the request is non-certified.

CHIROPRACTIC TREATMENT THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MANUAL THERAPY & MANIPULATION Page(s): 58-59.

Decision rationale: The California MTUS guidelines note chiropractic care is recommended as an option for the low back. The guidelines recommend a trial of 6 visits over 2 weeks; and with evidence of objective functional improvement, for a total of 18 visits over 6 to 8 weeks. For elective/maintenance care, it is not medically necessary. For recurrences/flare ups, the provider needs to re-evaluate treatment success. The patient was noted to have attended chiropractic care previously. There was a lack of documentation indicating the efficacy of the care. There was not a complete assessment provided demonstrating objective functional deficits which would benefit from chiropractic care as well as to be used as a baseline by which to assess objective functional improvements made during the course of care. The documentation provided indicated the patient has completed 7 sessions of chiropractic care; however, there was a lack of documentation indicating the efficacy of the prior chiropractic care. Therefore, the request is non-certified.