

Case Number:	CM13-0038400		
Date Assigned:	12/18/2013	Date of Injury:	12/06/2005
Decision Date:	05/05/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/25/2013

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 Internal Medicine and Pulmonary Diseases 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 is a 53-year-old male who reported an injury on 12/06/2005. The mechanism of injury was not provided for review. The patient ultimately underwent cervical fusion from the C3 to the C7 and lumbar fusion from the L4 to the S1. The patient was evaluated on 09/23/2013 and it was documented that the patient had ongoing cervical and lumbar pain. The patient's treatment history included trigger point injections and medication usage. It was noted that the patient had received at least 50% pain relief from previous trigger point injections. Physical findings included significant loss of range of motion of the cervical and lumbar spine, with tenderness to palpation throughout the lumbar musculature and notable antalgic gait favoring; and a positive straight leg raising test, with decreased sensation in the posterolateral thigh and posterolateral calf and dorsum of the right foot. The patient had mildly decreased reflexes of the Achilles tendon and decreased motor strength with dorsiflexion of the left ankle. The patient's medication schedule included Dilaudid 8 mg, Norco 10/325 mg, Neurontin 600 mg, Anaprox DS 550 mg, Prilosec 20 mg, trazodone 100 mg, Lidoderm patches, Fexmid 7.5 mg, Ambien 10 mg, and Robaxin 750 mg. It was noted that the patient was monitored for aberrant behavior with urine drug screens. The patient's diagnoses included status post L1-2 fusion, status post L4-5 and L5-S1 fusion, cervical fusion from the C3 to the C7, right lower extremity radiculopathy, facet joint arthropathy, cervical facet joint syndrome, cervical degenerative disc disease, reactionary depression, sacroiliac joint syndrome, and medication-induced gastritis. The patient's treatment plan included continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE FEXMID 7.5MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS, Page(s): 63.

Decision rationale: The Chronic Pain Guidelines do not recommend the long-term use of muscle relaxants. It is recommended that muscle relaxants be used for short durations of treatment not to exceed two to three (2 to 3) weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review indicates that the patient has been on muscle relaxants since at least 01/2013. The clinical documentation fails to provide any documentation of functional benefit or pain relief resulting from medication usage. Therefore, there is no support to extend treatment beyond the Guideline recommendations. As such, the retrospective request for Fexmid 7.5mg #60 is not medically necessary or appropriate.

RETROSPECTIVE 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, AND CARDIOVASCULAR RISKS Page(s): 68.

Decision rationale: The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 01/2013. There is a diagnosis included in the documentation of medication-induced gastritis. However, the patient's most recent clinical evaluation failed to provide an adequate assessment of the patient's gastrointestinal (GI) system. The Chronic Pain Guidelines recommend the use of gastrointestinal protectants for patients at risk for developing gastrointestinal events related to medication usage. The clinical documentation does not provide any recent evidence that the patient is at risk for developing medication-induced gastrointestinal events. As such, the requested retrospective request for Prilosec 20mg #60 is not medically necessary or appropriate.

RETROSPECTIVE 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, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The Chronic Pain Guidelines recommend that the continued use of opioids be supported by documented pain relief, functional benefit, managed side effects, and evidence

that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient is monitored for aberrant behavior with urine drug screens. However, the patient's most recent clinical documentation fails to provide any evidence of pain relief. There is no quantitative assessment of pain relief or documentation of functional benefit to support continued use. As such, the retrospective request for Norco 10/325mg #120 is not medically necessary or appropriate.

RETROSPECTIVE ANAPROX DS 550MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (NON-STEROIDAL ANTI-INFLAMMATORY DRUGS).

Decision rationale: The Chronic Pain Guidelines recommend the use of non-steroidal anti-inflammatory drugs (NSAIDs) in the management of chronic pain. However, the Guidelines also states that any medication used in the management of chronic pain must be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 01/2013. However, there is no documentation of significant functional benefit or pain relief as a result of the use of this medication. Therefore, continued use would not be supported. As such, the retrospective request for Anaprox DS 550mg #60 is not medically necessary or appropriate.