

Case Number:	CM13-0040060		
Date Assigned:	12/20/2013	Date of Injury:	06/02/2010
Decision Date:	03/27/2014	UR Denial Date:	09/26/2013
Priority:	Standard	Application Received:	10/08/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 physician 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 47-year-old female who reported an injury on 06/02/2010, secondary to repetitive work activity. The patient is diagnosed with L4-5 disc herniation, right L5 radiculitis, right L3-4 lateral disc herniation, status post L3-4 discectomy, and mild instability at L3-4. The patient was seen by [REDACTED] on 09/05/2013. The patient reported ongoing lower back pain with right lower extremity pain. Current medications included Dilaudid, Valium, Lidoderm, AcipHex, Relistor, and MS Contin. Physical examination revealed weakness in the tibialis anterior on the right with numbness in the lateral calf and anterior right thigh. Treatment recommendations included continuation of current medications as well as a lumbar back brace

IMR ISSUES, DECISIONS AND RATIONALES

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

Relistor 12mg/0.6ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation drugs.com website

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Opioid Induced Constipation Treatment.

Decision rationale: The California MTUS Guidelines state that prophylactic treatment of constipation should be initiated when starting opioid therapy. The Official Disability Guidelines state that opioid induced constipation treatment includes increasing physical activity, maintaining appropriate hydration, and advising the patient to follow a proper diet. As per the documentation submitted, there is no indication of gastrointestinal complaints or chronic constipation. There is also no evidence of a failure to respond to first line treatment, as recommended by the Official Disability Guidelines. The medical necessity for the requested medication has not been established. Therefore, Relistor is not medically necessary at this time.

Lidoderm patch 5%: 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 Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state that Lidocaine is indicated for neuropathic pain and localized peripheral pain after there has been evidence of a trial of first line therapy. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing treatment, the patient continues to report persistent pain in the lower back and right lower extremity. There is also no evidence of a trial of first line therapy with tricyclic or Serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressants, or anticonvulsants. Based on the clinical information received, Lidoderm patches are not medically necessary or appropriate

Valium 5mg tablet: 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 Page(s): 24.

Decision rationale: The California MTUS Guidelines state that benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. This patient has continuously utilized this medication. Despite ongoing treatment, the patient continues to report persistent pain. There is no change in the patient's physical examination that would indicate functional improvement. The medical necessity for the requested medication has not been established as the guidelines do not recommend long-term use of this medication. Therefore, Valium is not medically necessary or appropriate

AcipHex 20mg tablet: 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 Page(s): 68-69..

Decision rationale: The California MTUS Guidelines state that proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective nonsteroidal anti-inflammatory drug (NSAID). There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, AcipHex is not medically necessary at this time.

Voltaren topical gel: 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 Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state that the only approved topical NSAID is diclofenac, or Voltaren gel. Voltaren gel is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip, or shoulder. Therefore, Voltaren gel is not medically necessary or appropriate at this time

Dilaudid 4mg tablet: 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 Page(s): 74-82..

Decision rationale: The California MTUS Guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, Dilaudid is not medically necessary or appropriate.