

Case Number:	CM13-0049599		
Date Assigned:	12/27/2013	Date of Injury:	02/26/2011
Decision Date:	08/07/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	11/08/2013

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 and Rehabilitation, has a subspecialty in Pain Management, 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 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 injured worker is a 44-year-old injured on February 26, 2011 due to an undisclosed mechanism of injury. Current diagnoses include lumbar sprain/strain and lumbar degenerative joint disease. Prior MRI of the lumbar spine revealed disc protrusions at L4-5 and L5-S1 with congenitally small canal stenosis in the lumbar spine. Imaging studies revealed a healed L3 compression fracture without retropulsion. The clinical note dated October 22, 2013 indicates the injured worker presented complaining of ongoing back pain radiating into the bilateral lower extremities, posterior right lower extremity greater than left. The injured worker is requesting an epidural steroid injection and pain management consultation as previously discussed. The injured worker reports looking for employment opportunities and rating pain at 8/10 with the use of medications. The injured worker reports a 50% functional improvement with the use of medications. Current medications include Ultracet 2-4 tablets per day and Mobic. Physical examination reveals limited lumbar range of motion, straight leg raise positive bilaterally, altered sensory loss at the right lateral calf and bottom of the foot, difficulty ambulating, deep tendon reflexes are 1+ at the knees and ankles, and toes are down going to plantar reflex bilaterally. The documentation indicates current narcotic contract and consistent urine drug screens for prescribed medications. The injured worker was referred for pain consultation and epidural steroid injection. The initial request for Ultracet 37.5/325mg #120 and Mobic 15mg #30 was initially non-certified with modification on November 1, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultracet 37.5/325mg, 120 count: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is sufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic medications. Documentation indicated the injured worker experienced a 50% functional improvement with the use of medication. In addition, opioid risk assessments regarding possible dependence or diversion were also discussed. As the clinical documentation provided for review supports an appropriate evaluation for the continued use of narcotics as well as establishes the efficacy of narcotics, Ultracet 37.5/325mg, 120 count, is recommended as medically necessary at this time.

Mobic 15mg, thirty count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, NSAIDs, specific drug list & adverse effects Page(s): 70.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, non-steroidal anti-inflammatory medications (NSAIDs) are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that non-steroidal anti-inflammatory medications (NSAIDs) are more effective than acetaminophen for acute lower back pain. Package inserts for NSAIDs recommend periodic lab monitoring of a CBC (complete blood count) and chemistry profile (including liver and renal function tests). There is no documentation that these monitoring recommendations have been performed and the injured worker is being monitored on a routine basis. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. As such, the request for Mobic 15mg thirty count is not medically necessary or appropriate.