

Case Number:	CM13-0049926		
Date Assigned:	12/27/2013	Date of Injury:	04/14/1998
Decision Date:	12/04/2014	UR Denial Date:	10/30/2013
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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas & Ohio. 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 47-year-old female who reported an injury on 04/14/1998 due to an unspecified mechanism of injury. The injured worker had diagnoses of complex regional pain syndrome, left upper and left lower extremities; chronic pain syndrome; and status post spinal cord stimulator implant. The medications included Soma, Ambien, Norco, a Lidocaine patch, and Lidocaine cream, Prevacid, Ibuprofen, and OxyContin. The injured worker complained of pain to the neck and back region with numbness and weakness to the bilateral legs, left side greater than the right. Prior treatments included pain management, physical therapy x2 years, and a spinal cord stimulator. The objective findings dated 09/09/2013 revealed the injured worker had an antalgic gait and tenderness to palpation through the cervical, thoracic, and lumbar spine. There was decreased sensation and weakness to the left upper extremity and the left lower extremity. No diagnostics were available for review. No surgical history was noted. The treatment plan included medication refills. The Request for Authorization dated 12/27/2013 was submitted with documentation. The rationale for the Norco and OxyContin was to provide pain relief and increased function.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription of Ibuprofen 800mg PO TID, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) Page(s): 67-68.

Decision rationale: The request for a prescription of Ibuprofen 800 mg PO TID, #90 is not medically necessary. The California MTUS Guidelines recommend the use of NSAIDs for patients with osteoarthritis (including knee and hip) and patients with acute exacerbations of chronic low back pain. The guidelines recommended NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. In patients with acute exacerbations of chronic low back pain, the guidelines recommend NSAIDs as an option for short term symptomatic relief. The clinical documentation dated 05/08/2013 indicated that the injured worker was prescribed Ibuprofen in the clinical notes. The guidelines indicate that Ibuprofen should be used for exacerbations of chronic lower back pain at the recommended lowest dose for the shortest period in patients with moderate to severe pain. The provided stated in the clinical notes dated 09/09/2013 that the injured worker should be taken off the Ibuprofen due to the GI upset that it had caused. The current regimen was 3 times a day for a total of 2400 mg daily. Additionally, the request was for another 90 tablets, exceeding the recommended short term use for exacerbations of pain. The clinical notes did not provide the objective functional improvement with the medication. As such, the request is not medically necessary.

Prescription of Norco 5/325mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Norco, Ongoing Management Page(s): 75, 78.

Decision rationale: The request for a prescription of Norco 5/325 mg, #90 is not medically necessary. The California MTUS Guidelines recommend ongoing review of patient's utilizing chronic opioid medications with documentation of pain relief, functional status, appropriate medication use, and side effects. A complete pain assessment should be documented which includes current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The guidelines also recommend providers assess for side effects and the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. The documentation provided was not evident of measurable functions. The documentation did not address an ongoing pain management. The activities of daily living were not addressed. Adverse side effects were not addressed. The documentation did not provide a drug taking urinalysis. Additionally, the request did not address the frequency. As such, the request is not medically necessary.

Prescription of Oxycontin 30mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going Pain Management Page(s): 78.

Decision rationale: The request for a prescription of OxyContin 30 mg, #60 is not medically necessary. The California MTUS Guidelines recommend ongoing review of patient's utilizing chronic opioid medications with documentation of pain relief, functional status, appropriate medication use, and side effects. A complete pain assessment should be documented which includes current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The guidelines also recommend providers assess for side effects and the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. The clinical notes were not evident of documentation addressing any aberrant drug taking behavior or adverse side effects. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain. The request did not address the frequency. As such, the request is not medically necessary.

Prescription of Prevacid 30mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, and GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors, California GI Page(s): 68-69.

Decision rationale: The request for prescription of Prevacid 30 mg, #30 is not medically necessary. The California MTUS recommends proton pump inhibitors for the treatment of dyspepsia secondary to NSAID therapy. There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after the treatment duration has not been established. Routine blood pressure monitoring is recommended. The documentation indicated that the injured worker had a history of gastrointestinal issues with no current complaints of GI upset. Furthermore, the long term use of Ibuprofen was the cause of the GI upset. The request for Ibuprofen was not approved. The provider stated the Ibuprofen should be discontinued per the provided note dated 09/09/2013. The request did not address the frequency. Additionally, the documentation did not indicate that any lab work had been performed. As such, the request is not medically necessary.