

<b>Case Number:</b>	CM13-0058624		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	02/23/1998
<b>Decision Date:</b>	04/04/2014	<b>UR Denial Date:</b>	11/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/27/2013

### 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 53-year-old female who reported injury on 02/23/1999. The mechanism of injury was noted to be the patient had a metal drawer fall on her foot. The patient was noted to be taking Prilosec, Norco and Ambien in 11/2012 and Soma was added in 07/2013. The most recent documentation indicated that the patient had an exacerbation of acute low back pain with some radiation to lower extremities. The patient's diagnoses were noted to include right hip arthritis, and status post gastric bypass, left knee arthroplasty, left shoulder arthroscopy with subacromial decompression with residuals, open left rotator cuff repair, right hallux valgus deformity of great toe and lumbar radiculopathy. The treatment plan was noted to be due to the patient's acute exacerbation of low back pain the physician injected the patient with Toradol and the patient would be given prescriptions for Prilosec 20 mg, Ambien 10 mg, Norco 10/325, Motrin 800 mg, and Soma 350 mg as well as Biofreeze Gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Toradol 60mg injection.:** 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): 72.

**Decision rationale:** The MTUS Chronic Pain Guidelines do not recommend Toradol for minor or chronic painful conditions. Clinical documentation submitted for review indicated the physician was giving the injection for an acute exacerbation. However, there was a lack of documentation indicating the patient's efficacy of the Motrin as she was noted to be taking an over the counter NSAID. Given the above, Toradol is not recommended per the MTUS Chronic Pain Guidelines, and the request for Toradol 60 mg injection is not medically necessary and appropriate.

**Prilosec 20mg 1 qd #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

**Decision rationale:** The MTUS Chronic Pain Guidelines indicate that PPIs are recommended for the treatment of dyspepsia secondary to NSAID therapy. The patient was noted to be taking ibuprofen. The patient was taking Prilosec for greater than one year and there was a lack of documentation of the efficacy of the requested medication. Additionally, there was a lack of documentation indicating this patient had signs and symptoms of dyspepsia. Given the above, the request for Prilosec 20 mg 1 daily #30 is not medically necessary and appropriate.

**Ambien 10mg 1 hs prn #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Integrated Treatment/Disability Duration Guidelines, Stress & Mental Illness Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter section on Ambien.

**Decision rationale:** The Official Disability Guidelines indicate that Ambien is for the short term treatment of insomnia generally 2 to 6 weeks. Clinical documentation submitted for review indicated the patient had been taking the medication for greater than one year. There was a lack of documentation indicating the objective benefit of the medication. Given the above, the request for Ambien 10 mg 1 at bedtime as needed #30 is not medically necessary.

**Norco 10/325mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60, 78.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, objective decrease in the VAS score and evidence that the patient is being monitored for aberrant drug behavior and side effects. The patient was noted to be taking the medication for greater than 1 year and there was a lack of documentation of the above recommendations. Given the above, the request for Norco 10/325 one twice a day #60 is not medically necessary.

**Soma 350mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29..

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

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend muscle relaxants as a second line options for short term treatment of acute exacerbations of low back pain. Treatment is limited to less than 3 weeks. The patient should have documentation of objective functional improvement. The patient was noted to be taking the medication for greater than two months. There was a lack of documentation indicating the patient had objective functional improvement. Additionally, there was a lack of documentation necessitating the length of treatment longer than 3 weeks. Given the above, the request for Soma 350 mg 1 at bedtime #30 is not medically necessary.