MAXIMUS Federal Services

Case Number:	CM13-0058963		
Date Assigned:	02/21/2014	Date of Injury:	01/19/2001
Decision Date:	05/07/2014	UR Denial Date:	11/14/2013
Priority:	Standard	Application Received:	11/27/2013

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 Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Florida. 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 64-year-old female who reported an injury on 01/19/2001. The mechanism of injury was not provided for review. The injured worker ultimately developed chronic low back pain radiating into the bilateral lower extremities and chronic neck pain that radiated into the bilateral upper extremities in addition to chronic bilateral hip pain. The injured worker was evaluated on 11/04/2013. It was documented that the injured worker had pain rated at a 10/10 without medications that was reduced to a 7/10 with medications. It was noted that the injured worker complained of GI upset due to medications. The injured worker was evaluated for aberrant behavior with ongoing urine drug screens. The injured worker's medications included Carisoprodol, ibuprofen, hydrocodone, gabapentin, Zantac, Lunesta, Ondansetron, and Cyclobenzaprine. The injured worker's diagnoses included lumbar radiculopathy, lumbar disc degeneration, lumbar facet arthropathy, osteoarthritis of the right hip, opioid dependency, chronic pain, and medication related dyspepsia, and chronic nausea/ vomiting secondary to medications. Continuation of medication usage was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

ZANTAC 150MG TABLET #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA RANITIDINE

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: HTTP://WWW.RXLIST.COM/ZANTAC-DRUG/INDICATIONS-DOSAGE.HTM.

Decision rationale: The requested Zantac 150 mg tablets #60 are not medically necessary or appropriate. California Medical Treatment Utilization Schedule and Official Disability Guidelines do not specifically address this medication. An online resource rxlist.com does indicate that this medication is primarily used to control heartburn related to acid indigestion generally induced by food and beverages. The clinical documentation submitted for review does indicate that the injured worker has pain complaints of medication induced gastritis. However, there is no documentation of heartburn complaints that have failed to respond to nonpharmacological management such as nutritional adjustments. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request as it is submitted cannot be determined. As such, the requested Zantac 150 mg tablets #60 are not medically necessary or appropriate.

LUNESTA 3MG TABLET #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, INSOMNIA TREATMENTS.

Decision rationale: The requested Lunesta 3 mg tablets #30 are not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend Lunesta for short term relief of insomnia related complaints. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 03/2013. The most recent clinical evaluation submitted for review did not provide any evidence of insomnia complaints related to medication usage. Additionally, there was no evidence to support the efficacy of this medication. As the injured worker has been on this medication for an extended duration, continued use would not be supported. Also, the request as it is submitted does not identify a frequency of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested Lunesta 3 mg tablets #30 are not medically necessary or appropriate.

OXYCONTIN 60MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS; ON-GOING MANAGEMENT, Page(s): 78.

Decision rationale: The requested OxyContin 60 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends that opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation does indicate that the injured worker is monitored for aberrant behavior and has pain relief. It was documented that the injured worker had pain rated at a 10/10 that is reduced to a 7/10 with medication usage. However, specific functional benefit was not provided. Additionally, the request as it was submitted did not provide a frequency of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested OxyContin 60 mg #60 is not medically necessary or appropriate.

ONDANSETRON 4MG #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation U.S. FOOD AND DRUG ADMINISTRATION.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, ANTI-EMETICS

Decision rationale: The requested Ondansetron 4 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines state that nausea and vomiting complaints due to medication usage do not benefit from pharmacological management. Therefore, continued use of this medication would not be supported. Additionally, there is no documentation to support the efficacy of this medication that would provide support for ongoing usage. The request as it is submitted does not include a frequency of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested Ondansetron 4 mg #60 is not medically necessary or appropriate.

CYCLOBENZAPRINE 7-5MG #120: Upheld

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

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

Decision rationale: The requested Cyclobenzaprine 7.5 mg #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend long term use of muscle relaxants for the management of chronic pain. It is recommended that muscle relaxants be used for short durations not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation indicates that this injured worker has been on this

medication since at least 03/2013. The injured worker's most recent evaluation did not include evidence that this was an acute exacerbation of chronic pain that would benefit from a muscle relaxant. Therefore, continued use would not be supported. Additionally, the request as it is submitted did not provide a frequency of treatment. Therefore, the appropriateness of the request as it is submitted cannot be determined. As such, the requested Cyclobenzaprine 7.5 mg #120 is not medically necessary or appropriate.

GABAPENTIN 600MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MEDICATIONS FOR CHRONIC PAIN AND ANTIEPILEPSY DRUGS (AEDS), Page(s): 60; 16.. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MEDICATIONS FOR CHRONIC PAIN AND ANTIEPILEPSY DRUGS (AEDS), 60; 16

Decision rationale: The requested gabapentin 600 mg #180 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends anticonvulsants as first line medications for chronic pain. However, California Medical Treatment Utilization Schedule recommends that continued use be supported by significant functional benefit and documentation of pain relief. The clinical documentation does indicate that the injured worker has pain relief rated at a 10/10 without medications reduced to a 7/10 with medications. However, functional benefit is not specifically identified within the submitted documentation. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested gabapentin 600 mg #180 is not medically necessary or appropriate.

HYDROCODONE APAP 10/325MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS; ON-GOING MANAGEMENT, Page(s): 78.

Decision rationale: The requested hydrocodone/APAP 10/325 mg #180 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends that opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation does indicate that the injured worker is monitored for aberrant behavior and has pain relief. It was documented that the injured worker had pain rated at a 10/10 that is reduced to a 7/10 with medication usage. However, specific functional benefit was not provided. Additionally, the request as it was submitted did not provide a frequency of treatment. Therefore, the appropriateness of the request

cannot be determined. As such, the requested hydrocodone/APAP 10/325 mg #180 is not medically necessary or appropriate.

IBUPROFEN 800MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MEDICATIONS FOR CHRONIC PAIN; ONGOING MANAGEMENT, Page(s): 60; 67..

Decision rationale: The requested ibuprofen 800 mg #180 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does support the use of nonsteroidal anti-inflammatory drugs for the management of chronic physical pain. However, California Medical Treatment Utilization Schedule recommends the ongoing use of medications for chronic pain be supported by documentation of functional benefit and pain relief. The clinical documentation does indicate that the injured worker has pain relief rated at a 10/10 without medications reduced to a 7/10 with medications. However, specific functional benefit was not provided within the submitted documentation. Also, the request as it is submitted does not identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested ibuprofen 800 mg #180 is not medically necessary or appropriate.

CARISOPRODOL 350MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29,65..

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

Decision rationale: The requested Carisoprodol 350 mg #180 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend long term use of muscle relaxants for the management of chronic pain. It is recommended that muscle relaxants be used for short durations not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation indicates that this injured worker has been on this medication since at least 03/2013. The injured worker's most recent evaluation did not include evidence that this was an acute exacerbation of chronic pain that would benefit from a muscle relaxant. Therefore, continued use would not be supported. Additionally, the request as it is submitted did not provide a frequency of treatment. Therefore, the appropriateness of the request as it is submitted cannot be determined. As such, the requested Carisoprodol 350 mg #180 is not medically necessary or appropriate.