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| Case Number: | CM13-0062654 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 08/09/2011 |
| Decision Date: | 06/09/2014 | UR Denial Date: | 11/21/2013 |
| Priority: | Standard | Application Received: | 12/09/2013 |

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 Georgia. 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 patient is a 44-year-old male who sustained an injury on 08/09/11, when he slipped and fell causing injury to the low back. The patient was followed for continuing complaints of low back pain and treated with physical therapy and chiropractic therapy. The patient had prior surgical procedures for the thoracolumbar spine, due to an unrelated injury, which resulted in residual right foot drop. The previous urine drug screen results from 08/23/13 were negative for medications. This was not a confirmatory result. The patient was seen by [REDACTED] on 10/04/13, with ongoing complaints of low back pain rating 8/10 on the visual analog scale (VAS). The pain radiated to the left lower extremity. The patient described some side effects from the use of Topiramate. The patient also reported side effects from Diclofenac, including heartburn. There was partial benefit obtained with the use of Hydrocodone. On physical examination, the patient described pain with lumbar extension. There was an antalgic gait. No side effects from medications were noted. Protonix 20mg was prescribed with Depakote extended release 500mg, Hydrocodone 10/325mg and Tramadol extended release 150mg. Senokot was also prescribed at this visit. The follow-up with [REDACTED] on 11/01/13 indicated that the patient had improvement of pain with the new prescription medications. The patient continued to report low back pain 9/10 on VAS, radiating to the lower extremities. On physical examination, there continued to be pain with lumbar range of motion. No obvious neurological deficit was identified. There was recommendation for the patient to be seen by a spinal surgeon. The treating provider requested Protonix 20mg (Pantoprazole), Hydrocodone 10/325mg (Norco) #90, Tramadol ER 150mg #30 and Depakote ER 150mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

PROTONIX 20 MG (PANTOPRAZOLE): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI SYMPTOMS AND CARDIOVASCULAR RISK Page(s): 68-69.

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, PROTON PUMP INHIBITORS.

Decision rationale: The patient reported side effects from the medications including diclofenac, such as heartburn. Given the gastric upset induced by the prescribed medications, the use of a proton pump inhibitor to address these side effects would be considered medically appropriate and necessary. Therefore, this reviewer recommends this medication as medically necessary.

HYDROCODONE 10/325 MG (NORCO) #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, SPECIFIC DRUG LIST Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 88-89.

Decision rationale: The Chronic Pain Guidelines indicate that for long-term use of opioids, the provider should document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. The patient was started on 10/325mg hydrocodone in October of 2013. The clinical documentation submitted for review did not clearly establish the functional benefit obtained with the change in this medication. There was no evidence of any substantial functional improvement or pain reduction with this medication. Given the lack of any clinical indication that the patient had substantially improved functional ability or decreased pain, this reviewer does not recommend this medication as medically necessary. Furthermore the clinical documentation did not provide any confirmatory urine toxicology results establishing compliance as recommended by guidelines.

TRAMADOL ER 150 MG, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, SPECIFIC DRUG LIST Page(s): 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 88-89.

Decision rationale: The Chronic Pain Guidelines indicate that for long-term use of opioids, the provider should document pain and functional improvement and compare to baseline.

Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. The patient was started on 10/325mg hydrocodone in October of 2013. The clinical documentation submitted for review did not clearly establish the functional benefit obtained with the change in this medication. There was no evidence of any substantial functional improvement or pain reduction with this medication. Given the lack of any clinical indication that the patient had substantially improved functional ability or decreased pain, this reviewer does not have recommend this medication as medically necessary. Furthermore, the clinical documentation did not provide any confirmatory urine toxicology results establishing compliance as recommended by guidelines.

DEPAKOTE ER 150 MG, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
[HTTP://WWW.NCBI.NLM.NIH.GOV/PUBMED/21861814](http://www.ncbi.nlm.nih.gov/pubmed/21861814).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIEPILEPSY DRUGS (AEDs), Page(s): 16-17.

Decision rationale: The Chronic Pain Guidelines indicate that antiepileptic drugs are recommended for neuropathic pain. Physical examination findings did not identify any specific neurological deficit other than residual right foot drop that would have required the use of an anticonvulsant medication to address neuropathic pain. It was noted the patient had reported side effects with topiramate. There was no other clinical documentation indicating that other first line medications for neuropathic pain such as gabapentin or Lyrica had been tried or were not tolerated. There was also no clear indication that the patient had any substantial functional benefit or pain reduction with this medication that would have supported its use. Therefore this reviewer does not recommend this medication as medically necessary.