MAXIMUS Federal Services

Case Number:	CM13-0064746		
Date Assigned:	01/03/2014	Date of Injury:	07/21/2008
Decision Date:	05/23/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/12/2013

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 Medicine and is licensed to practice in Texas and Oklahoma. 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 45-year-old male who reported injury on 07/21/2008. The mechanism of injury was not provided. The documentation submitted for review indicated that the injured worker had been utilizing Protonix, Sentra PM, diclofenac and muscle relaxants, Hydrocodone, Ketamine 5% cream and Colace for greater than six (6) months. The documentation of 11/14/2013 revealed that the injured worker had a complaint of low back pain. The diagnosis was lumbar disc displacement without myelopathy. The treatment plan included a home exercise program, a multi-functional Restoration Program and medication refills as it was indicated the medications helped improve the injured worker's pain and function.

IMR ISSUES, DECISIONS AND RATIONALES

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

PROTONIX 20MG #60, WITH NO REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, PAIN CHAPTER, PROTON PUMP INHIBITORS (PPIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (NON-STEROIDAL ANTI-INFLAMMATORY DRUGS) Page(s): 69.

Decision rationale: The Chronic Pain Guidelines recommend proton pump inhibitors (PPIs) for the treatment of dyspepsia secondary to non-steroidal anti-inflammatory drug (NSAID) therapy. The documentation of 11/14/2013 failed to indicate that the injured worker had signs and symptoms of dyspepsia. The injured worker was noted to be utilizing the medication for greater than six (6) months. The request as submitted failed to indicate the frequency. Given the above, the request for Protonix 20 mg #60 with no refills is not medically necessary or appropriate.

SENTRA PM MEDICAL FOOD #60, WITH THREE (3) REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES: MENTAL AND STRESS CHAPTER, SENRA PM.

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, SENTRA PM.

Decision rationale: The Official Disability Guidelines indicate that Sentra PM is a medical food for the management of sleep disorder associated with depression. The clinical documentation submitted for review indicated that the injured worker had been utilizing the medication for greater than six (6) months. There was a lack of documentation of the functional benefit received from the medication. Additionally, the request as submitted failed to indicate the frequency and the necessity for three (3) refills. Given the above, the request for Sentra PM medical food #60 with three (3) refills is not medically necessary or appropriate.

DICLOFENAC SODIUM 1.5% CREAM #1, WITH NO REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

Decision rationale: The Chronic Pain Guidelines indicate that topical analgesics are experimental in use, with few randomized controlled trials to determine efficacy or safety. The Guidelines also indicate that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical non-steroidal anti-inflammatory drugs (NSAIDs) have been shown in meta-analysis to be superior to placebo during the first two (2) weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. The clinical documentation submitted for review indicated that the injured worker had been utilizing the medication for greater than six (6) months. There was a lack of documentation of the efficacy of the requested medication. The request as submitted failed to indicate the frequency for the medication. Given the above, the request for diclofenac sodium 1.5% cream #1, with no refills is not medically necessary or appropriate.

ROBAXIN 500MG #90, WITH TWO (2) REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN).

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

Decision rationale: The Chronic Pain Guidelines do not recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than three (3) weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated that the injured worker had been utilizing the medication for greater than six (6) months. There was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency for the medication. Given the above, the request for Robaxin 500 mg #90 with no refills is not medically necessary or appropriate.

HYDROCODONE 5/325MG #30, WITH NO REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines WHEN TO CONTINUE OPIOIDS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, PAIN CHAPTER, OPIOIDS FOR CHRONIC PAIN.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MEDICATIONS FOR CHRONIC PAIN AND ONGOING MANAGEMENT Page(s): 60 AND 78.

Decision rationale: The Chronic Pain Guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the patient is being monitored for aberrant drug behavior and side effects. The clinical documentation indicated that the injured worker had been utilizing the medication for more than six (6) months. There was a lack of documentation of the above recommendations. The request as submitted failed to include the frequency for the requested medication. Given the above, Hydrocodone 5/325mg, #30, with no refills is not medically necessary.

KETAMINE 5% CREAM, WITH NO REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

Decision rationale: The Chronic Pain Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety, and are primarily recommended for neuropathic pain when trials of antidepressants and

anticonvulsants have failed. The Guidelines also indicate that any compounded product that contains at least one (1) drug (or drug class) that is not recommended is not recommended. Regarding the use of Ketamine it is under study and is only recommended in treatment of neuropathic pain which is refractory to all primary and secondary treatment. The injured worker had been on the medication for more than six (6) months. There was a lack of documentation of an objective decrease in pain and objective increase in function to support the usage. Additionally there was a lack of documentation indicating the injured worker's pain was resistant to all primary and secondary treatments. The request as submitted failed to include the quantity and the frequency for the requested medication. Given the above, the request for Ketamine 5% Cream, with no refills is not medically necessary.

DOCUSATE SODIUM 100MG #60, WITH FIVE (5) REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ROBERTS PHARMACEUTICAL (2004), COLACE ORAL, COLACE, DIALOSE, DSS, SURFAK (DOCUSATE SODIUM).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 77.

Decision rationale: The Chronic Pain Guidelines indicate that when starting opioid therapy, prophylactic treatment of constipation should be initiated. The clinical documentation submitted for review indicated that the injured worker had been utilizing the medication for more than six (6) months. There was a lack of documentation of the effectiveness of the medication. There was a lack of documentation to support five (5) refills without re-evaluation. The request, as submitted failed to include the frequency for the requested medication. Given the above, the request for Docusate Sodium 100mg, #60, with five (5) refills is not medically necessary.