

Case Number:	CM13-0068508		
Date Assigned:	01/03/2014	Date of Injury:	04/25/2000
Decision Date:	06/05/2014	UR Denial Date:	12/09/2013
Priority:	Standard	Application Received:	12/19/2013

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 Management 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 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 55-year-old female who reported an injury on 04/25/2000, when she was struck in the face with a set of keys. The injured worker reportedly sustained an injury to her cervical spine. The injured worker's treatment history included physical therapy, a home exercise program, multiple medications, epidural steroid injections, B12 injections, and aquatic therapy. The injured worker was evaluated on 11/20/2013. It was documented that the injured worker had pain rated at a 7/10 with medications that increased to a 9/10 without medications. The injured worker's medication schedule included vitamin D, Tizanidine, Pantoprazole, Senokot-S, Hydrocodone, a Butrans patch, and Naprosyn 500. Physical findings included tenderness to palpation of the lumbar paravertebral musculature and cervical paravertebral musculature. The injured worker's diagnoses at that time included lumbar radiculopathy, cervical radiculopathy, myalgia/myositis, fibromyalgia, chronic pain, vitamin D deficiency, medication-related dyspepsia, status post spinal cord stimulation explant, and chronic nausea and vomiting. The injured worker's treatment plan included B12 injection, aquatic therapy, and continuation of medications. The injured worker was examined on 01/02/2014. It was documented that a reconsideration of the non-certification for previously requested aquatic therapy, Neurontin, Tizanidine, Naprosyn, Pantoprazole, Hydrocodone/APAP, and Senokot was submitted. It was documented that the injured worker had previously had a positive response to aquatic therapy. It was documented that the injured worker had signed and complied with an opioid pain agreement and did not exhibit any red flag signs or symptoms of abuse. However, no other clinical support or information was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE B12 INJECTION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

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, Vitamin B.

Decision rationale: The requested 1 B12 injection is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address this request. Official Disability Guidelines do not recommend vitamin B in the management of chronic pain, as there is little scientific evidence to support the efficacy and safety of this treatment. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested vitamin B injections are not medically necessary or appropriate.

UNKNOWN ADDITIONAL AQUATIC THERAPY SESSIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

Decision rationale: The requested unknown additional aquatic therapy sessions are not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends aquatic therapy for injured workers who require a non-weight bearing environment to participate in active therapy. The clinical documentation submitted for review does indicate that the injured worker has previously participated in aquatic therapy with benefit. However, the injured worker's most recent clinical documentation does not provide any evidence that injured worker cannot participate in a land-based program and requires a non-weight bearing environment. Additionally, the request as it is submitted does not clearly identify a frequency or body part. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested unknown additional aquatic therapy sessions are not medically necessary or appropriate.

ONE PRESCRIPTION OF NEURONTIN 300MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epileptics Page(s): 16.

Decision rationale: The requested prescription of Neurontin 300 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of anticonvulsants as a first-line medication in the management of chronic pain. However, the use of anticonvulsants must be supported by documented functional benefit and at least 30% pain relief. The clinical documentation submitted for review does indicate that the injured worker has a reduction in pain from a 9/10 to a 7/10. However, this would not be considered at least a 30% reduction in pain. Therefore, the efficacy of this medication is not established. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested Neurontin 300 mg #60 is not medically necessary or appropriate.

ONE PRESCRIPTION FOR TIZANIDINE HCL 2MG #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES.

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

Decision rationale: The requested prescription of Tizanidine hydrochloride 2 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends muscle relaxants for short-term treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. California Medical Treatment Utilization Schedule does not recommend the long-term use of muscle relaxants in the management of chronic pain. The requested 90 tablets exceed this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. 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 Tizanidine hydrochloride 2 mg #90 is not medically necessary or appropriate.

ONE PRESCRIPTION FOR NAPROSYN 500MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications For Chronic Pain and NSAIDS Page(s): 60,67.

Decision rationale: The requested Naprosyn 500 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of nonsteroidal anti-inflammatory drugs in the management of chronic pain. However, medications used in the management of chronic pain must be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review does indicate that the injured worker has pain relief from a 9/10 to a 7/10 with medication usage,

although this is not considered significant. Additionally, there is no documentation of significant functional benefit resulting from the use of medications. Therefore, continued use of this medication would not be supported. As such, the requested prescription for Naprosyn 500 mg #60 is not medically necessary or appropriate.

ONE PRESCRIPTION FOR PANTOPROZOLE SODIUM DR 20MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: The requested Pantoprazole is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of gastrointestinal protectants be supported by documentation that the injured worker is at risk for developing gastrointestinal disturbances related to medication usage. The most recent clinical documentation does not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at risk or at continued risk for developing gastrointestinal symptoms. The clinical documentation does not provide any evidence that the injured worker complains of side effects related to medication usage. Therefore, continued use of this medication would not be supported. Additionally, the request does not include a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested 1 prescription for Pantoprazole sodium DR 20 mg #30 is not medically necessary or appropriate.

HYDROCODONE/APAP 10/325MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 77.

Decision rationale: The requested Hydrocodone/APAP 10/325 mg #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, documentation of functional benefit, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is engaged in an opioid pain contract and does not exhibit any symptoms that put them at risk for aberrant behavior. Additionally, it is noted within the documentation that the injured worker has a reduction in pain from a 9/10 to a 7/10. However, the clinical documentation fails to identify any functional benefit related to medication usage. Therefore, continued use would not be supported. 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 request Hydrocodone/APAP 10/325 mg #120 is not medically necessary or appropriate.

ONE PRESCRIPTION OF SENOKOT-S 8.6-50MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Initiating Therapy Page(s): 77.

Decision rationale: The requested prescription of Senokot-S 8.6/50 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the prophylactic treatment of constipation in the management of chronic pain when opioids are used for long-term treatment. The clinical documentation submitted for review does indicate that the injured worker has been on opioid medications for an extended duration of time. However, continued use of this medication is not supported, as there is no documentation of an ongoing need due to complaints of constipation. There is no documentation the injured worker has continued complaints that require pharmacological intervention. 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 1 prescription of Senokot-S 8.6/50 mg #60 is not medically necessary or appropriate.

ONE PRESCRIPTION FOR BUTRANS PATCHES 10MCG #4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 125-126.

Decision rationale: The requested 1 prescription of Butrans patches 10 mcg #4 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of this medication for injured workers who have chronic pain. However, medications used in the management of chronic pain should be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review does indicate that the injured worker has a reduction in pain from 9/10 to 7/10. However, functional benefit related to medication usage was not provided within the documentation. Therefore, continued use of this medication would not be supported. Additionally, the request fails to identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Butrans patches 10 mcg #4 is not medically necessary or appropriate.