

<b>Case Number:</b>	CM14-0002412		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	05/10/1999
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	12/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 & 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 67-year-old female who reported an injury on 05/10/1999. The mechanism of injury was not specifically stated. Current diagnoses include chronic pain, failed back surgery syndrome, lumbar radiculopathy, status post lumbar fusion, insomnia, and status post spinal cord stimulator implantation. The injured worker was evaluated on 01/06/2014. The injured worker reported 5/10 lower back pain with radiation into bilateral lower extremities. Current medications include Soma, Fioricet, hydrocodone/APAP, Protonix, Senokot-S, vitamin D, and Ambien. Physical examination on that date revealed limited lumbar range of motion, tenderness to palpation, and an unchanged sensory examination. Treatment recommendations at that time included continuation of current medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PROTONIX 20MG #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): 68-69.

**Decision rationale:** The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the injured worker does not meet criteria for the use of a proton pump inhibitor. Additionally, there is no frequency listed in the current request. As such, the request for PROTONIX 20 MG #60 is non-certified.

**VITAMIN D 2,000 UNIT #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Vitamin D (cholecalciferol).

**Decision rationale:** The Official Disability Guidelines state vitamin D is recommended in consideration for chronic pain patients and supplementation if necessary. The injured worker has utilized this medication since 07/2013, without any evidence of objective functional improvement. There is no mention of a vitamin D deficiency. As the medical necessity has not been established, the current request is not medically appropriate. Additionally, there is no frequency listed in the current request. As such, the request for VITAMIN D 2,000 UNIT #90 is non-certified.

**SENOKOT-S 8.6-50MG #30:** 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): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain chapter, Opioid Induced Constipation Treatment.

**Decision rationale:** The California MTUS Guidelines state prophylactic treatment of constipation should be initiated when also initiating opioid therapy. The Official Disability Guidelines state first line treatment for opioid induced constipation includes increasing physical activity, maintaining appropriate hydration, and advising the patient to follow a proper diet. There is no evidence of chronic constipation. There is also no documentation of a failure to respond to first line treatment as recommended by the Official Disability Guidelines. There is also no frequency listed in the current request. As such, the request for SENOKOT-S 8.6-50 MG #30 is non-certified.

**CARISOPRODOL 350MG #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): 63-66 and 124.

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. Soma should not be used for longer than 2 to 3 weeks. The injured worker has utilized this medication since 07/2013, without any evidence of objective functional improvement. There was no evidence of palpable muscle spasm or spasticity upon physical examination. There is also no frequency listed in the current request. As such, the request for CARISOPRODOL 350 MG #60 is non-certified.

**ZOLPIDEM TARTRATE 10MG #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) Chronic Pain chapter, Insomnia Treatment.

**Decision rationale:** The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. There is no documentation of chronic insomnia. There is also no evidence of a failure to respond to non-pharmacologic treatment. There is no frequency listed in the current request. As such, the request for ZOLPIDEM TARTRATE 10 MG #30 is non-certified.

**FLORICET 50-325-40MG #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:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

**Decision rationale:** The California MTUS Guidelines state barbiturate containing analgesic agents are not recommended for chronic pain. There is a risk of medication overuse as well as rebound headache. Therefore, the current request is not medically appropriate. As such, the request for FLORICET 50-325-40 MG #30 is non-certified.