MAXIMUS Federal Services

Case Number:	CM14-0006383		
Date Assigned:	02/05/2014	Date of Injury:	12/22/1999
Decision Date:	06/20/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/14/2014

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 Orthopedic Surgery, and is licensed to practice in California. 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 38 year old individual with a date of injury of December 22, 1999. A prior review of this request was denied on December 31, 2013. A progress note dated January 16, 2014 is provided for review indicating that the claimant is seen for follow-up for back pain rated 5/10. The mechanism of injury reported was a slip off of the scaffold with multiple injuries to the right leg, left arm, low back, and hip. The record indicates that the claimant was previously prescribed Norco, which was denied and had been helping him. A home exercise program is referenced to be ongoing. No significant symptomatic or functional changes are noted. Physical examination reveals an antalgic gait on the left. Spring testing increases groin and buttock pain. Pain is greater on lumbar extension than flexion, but those are noted to be quite painful. Pain is present. Iliopsoas tenderness is reported. The clinical diagnosis noted is chronic low back pain, clinically consistent with lumbar mechanical pain, “discal and facetal with possible sacroiliac component”. There’s a notation in the medical records provided for review that the clinic will be closing on February 14, 2014 and that the claimant will need to find replacement doctor. The treatment recommendation is for continued medications, including Cyclobenzaprine 7.5 mg 1 PO TID, PRN, #90; Naproxen 550 mg, 1 PO b.i.d.; Norco 325-10, ½-1 PO Q8 hours; Topamax 100 mg, 1 PO b.i.d. #60; result with them 5 mg ½-1 PO QHS #30; Trazodone 1 PO QHS; Tramadol cream; Duexis, b.i.d., #60, refills 5; Pantoprazole 20

mg for dyspepsia from pain medication, 1 PO QD #30. Pharmacotherapy has been the primary treatment recommendation, a home exercise program is referenced, and there is one comment in a remote progress note of prior physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

NAPROXEN SODIUM 550MG 1 TAB ORALLY 2X/DAY #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): 21.

Decision rationale: This is a non-selective, non-steroidal anti-inflammatory medication which has some indication for the treatment of various inflammatory conditions. The maximum recommended dose is 550mg twice per day. It is indicated for treatment of this claimant's medical conditions. The medical records provided for review offer no objective documentation of efficacy noted with the use of this medication on a chronic basis. In the absence of the appropriate documentation, and when considering the multiple medications utilized on a chronic basis, there is no clear clinical indication of the efficacy of this medication on a chronic basis. Based on the clinical data available, this request is not medically necessary and appropriate.

NORCO 10-325MG 1/2-1 TAB BY MOUTH EVERY 8 HRS #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

Decision rationale: Norco (Hydrocodone/acetaminophen) 10/325 is a branded combination of a short-acting opioid, hydrocodone, with acetaminophen. It is available as a generic equivalent formulation. If used as prescribed, up to 3 pills per day, the MED is 30mg per day and the daily acetaminophen load is 975mg. the progress note provided in support of this request does not reference objective evidence of efficacy noted with this medication. There is no documentation of the pain level on the VAS. Additionally, there is no documentation of a signed opioid agreement. A urine drug screen is noted. In the absence of functional improvement the request is not medically necessary and appropriate.

ORPHENADRINE 100MG 1 TAB BY MOUTH EVERY 12-24 HRS #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: According to the MTUS Chronic Pain Guidelines, this medication has abuse potential due to a reported euphoric and mood elevating effect, and therefore should be used with caution as a 2nd line option for short-term use in both acute and chronic low back pain. Based on the clinical documentation provided, the clinician does not document trials of any previous anticonvulsant medications or medications for chronic pain. Given the MTUS recommendations that this be utilized as a 2nd line agent and for short-term use, the request is deemed not medically necessary and appropriate.

ZOLPIDEM 5MG #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: This medication is a short acting non-benzodiazepine hypnotic approved for the short-term treatment of insomnia (2-6 weeks). When used on a long-term basis. These medications can be habit-forming, and may impair function and memory more than opioid pain relievers, and can increase pain over the long-term. The long-term use of this medication is not supported and is discouraged by the ODG. Since this medication is being used on a long-term basis, this request is therefore not medically necessary and appropriate.