

Case Number:	CM14-0007038		
Date Assigned:	02/07/2014	Date of Injury:	08/14/2004
Decision Date:	06/20/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/15/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in New York and 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 patient is a 44-year-old female who sustained an injury on 08/14/04 due to cumulative trauma while working. The patient was followed for ongoing complaints of chronic low back pain radiating to the right lower extremity and neck pain radiating to the right upper extremity. The patient was managed with multiple medications for pain and previous Toradol injections and injections for B12. The medications included MS Contin 60mg twice daily for pain. The 10/23/13 clinical record noted that the patient had pain levels 8.5/10 with medications and 9.5/10 without medications. There was an inconsistent pill count as the patient stated her morphine was dropped into a toilet. The patient appeared alert and appropriate but agitated. Additional Toradol injections and B12 injections were provided at this visit. Other medications being prescribed to the patient included gabapentin 600mg three times daily, naproxen 550mg twice daily, omeprazole 20mg daily, Compazine 10mg every eight hours as needed, Robaxin 750mg three times daily, Ambien 10mg daily at night, Norco 10/325mg every eight hours for pain and Trixaicin .075% cream applied one to two times a day. Previous urine drug screens from November of 2012 noted consistent findings with prescribed medications for the exception of hydrocodone. More recent urine drug screen findings from January of 2013 noted positive findings for multiple benzodiazepines, hydrocodone, and Zolpidem. There was a non-confirmatory urine drug screen from 11/13/13 which was negative for any opioid medications and oxycodone. Confirmatory qualitative results showed positive results for both morphine and hydrocodone. The last urine drug screen from 01/08/14 showed consistent findings for morphine and hydrocodone. There was a negative result for Zolpidem. Follow up on 11/07/13 noted minimal change with medications in regards to pain. Physical examination noted antalgic and slow gait with lumbar with reduced lumbar range of motion and tenderness to palpation in the

lumbar spine. Medications were continued at this visit. The patient returned on 12/05/13. Pain levels continued to be very high with even with medications. Physical examination was unchanged and medications were continued at this visit. The requested MS Contin 60mg quantity 60, Norco 10/325mg quantity 90, Ambien 10mg quantity 30, Trixaicin quantity 120, Robaxin 750mg quantity 60, Compazine 10mg quantity 60, and omeprazole 20mg quantity 30 were all denied by utilization review on 12/31/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

MS CONTIN 60MG TABLET, TAKE ONE (1) TABLET TWICE DAILY AS NEEDED FOR PAIN FOR 30 DAYS, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 76-80.

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

Decision rationale: In regards to the use of MS Contin 60mg quantity 60, the request is not medically necessary based on the clinical documentation provided for review and the MTUS guidelines recommendations. From the clinical documentation submitted for review there is no indication of any substantial functional improvement or pain reduction with MS Contin for round the clock pain relief. Pain scores were still severe ranging from 8-9/10 out of 10 on visual analog scale (VAS). There was no indication of any clear functional benefit with the continued use of MS Contin. Per MTUS guidelines there should be evidence of functional improvement and substantial pain reduction to support the continued use of narcotic medications, which are not recommended for long term use in chronic musculoskeletal pain. Without clear evidence of any substantial functional improvement or pain reduction obtained with MS Contin, the request is not certified.

NORCO 10/325MG, ONE (1) TABLET BY MOUTH EVERY 8 HOURS FOR PAIN FOR 30 DAYS, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ONGOING MANAGEMENT, Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing management, Page(s): 88-89.

Decision rationale: In regards to the use of Norco 10/325mg quantity 90, the request is not medically necessary based on the clinical documentation provided for review and the MTUS guidelines recommendations. From the clinical documentation submitted for review there is no indication of any substantial functional improvement or pain reduction with Norco for breakthrough pain relief. Pain scores were still severe ranging from 8-9/10 out of 10 on visual analog scale (VAS). There was no indication of any clear functional benefit with

the continued use of Norco. Per MTUS guidelines there should be evidence of functional improvement and substantial pain reduction to support the continued use of narcotic medications, which are not recommended for long term use in chronic musculoskeletal pain. Without clear evidence of any substantial functional improvement or pain reduction obtained with Norco, the request is not certified.

AMBIEN 10MG, ONE (1) TABLET AT BEDTIME FOR INSOMNIA FOR 30 DAYS, #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), STRESS & MENTAL ILLNESS CHAPTER, ZOLPIDEM (AMBIEN).

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, ZOLPIDEM (AMBIEN).

Decision rationale: In regards to the use of Ambien 10mg quantity 30, the request is not medically necessary medically necessary based on the clinical documentation provided for review and the Official Disability Guidelines (ODG) recommendations. The use of Ambien to address insomnia is recommended for a short-term duration no more than 6 weeks per current evidence based guidelines. Furthermore, the Food and Drug Administration (FDA) has recommended that dosing of Ambien be reduced from 10mg to 5mg due to adverse effects. The clinical documentation submitted for review does not provide any indications that the use of Ambien has been effective in improving the claimant's overall functional condition. Furthermore, the last toxicology result identified a negative finding for Ambien which was not addressed in the clinical documentation. As such, the request is not certified.

TRIXAICIN HP 0.075% CREAM, APPLY AS DIRECTED BY PHYSICIAN (1-2 TIMES DAILY) FOR 30 DAYS, #120: Upheld

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

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

Decision rationale: In regards to the use of Trixaicin .075% quantity 120, the request is not medically necessary medically necessary based on the clinical documentation provided for review and the MTUS guidelines recommendations. Trixaicin contains capsaicin which can be considered an option in the treatment of neuropathic symptoms when other treatments have failed or were not tolerated. There is no indication from the records to support that the claimant has failed all reasonable treatment alternatives for neuropathic pain which would support the use of a topical analgesic. As the MTUS guidelines consider most topical analgesics experimental and investigational due to the lack of evidence in the current clinical literature to support their use in the treatment of chronic pain, the request is not certified.

ROBAXIN 750MG, ONE (1) TABLET EVERY 8 HOURS FOR 20 DAYS, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANT, Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANT, Page(s): 63-67.

Decision rationale: In regards to the use of Robaxin 750mg quantity 60, the request is not medically necessary medically necessary based on the clinical documentation provided for review and the MTUS guidelines recommendations. The chronic use of muscle relaxers is not recommended by MTUS guidelines. At most, muscle relaxers are recommended for short term use only. The efficacy of chronic muscle relaxer use is not established in the clinical literature. There is no indication from the clinical reports that there had been any recent exacerbation of chronic pain or any evidence of a recent acute injury. Therefore, the request is not certified.

COMPAZINE 10MG TABLET, BY MOUTH (P.O) EVERY EIGHT (8) HOURS AS NEEDED (Q 8 PRN) FOR 30 DAYS, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISK. Page(s): 68. Decision based on Non-MTUS Citation <http://www.drugs.com/mtm/compazine.html>

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, Anti-emetics.

Decision rationale: In regards to the use of Compazine 10mg quantity 60, the request is not medically necessary medically necessary based on the clinical documentation provided for review and the Official Disability Guidelines (ODG) recommendations. The clinical documentation did not specifically identify any substantial side effects with the current pain medication regimen including nausea or vomiting that would have supported the use of this medication. Per ODG, anti-emetics for chronic opioid use are not recommended. Rather the recommendation is to adjust medications to avoid side effects. Without any other indications for Compazine, the request is not certified.

OMEPRAZOLE 20MG CAPSULE BY MOUTH ONE TIME DAILY FOR 30 DAYS, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISK,.

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: In regards to the use of Omeprazole 20mg quantity 30, the request is not medically necessary medically necessary based on the clinical documentation provided for review and the Official Disability Guidelines (ODG) recommendations. The patient is taking multiple medications for pain; however, there are no clear indications emanating gastrointestinal side effects from use of these medications that would support the use of proton pump inhibitor. Otherwise, there is no evidence of ongoing gastroesophageal reflux disease that would also support the use of this medication. Therefore, the request is not certified.

NAPROXEN SODIUM 550MG TAB, TAKE ONE (1) TABLET BY MOUTH TWICE A DAY FOR 30 DAYS, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISK,.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES , ,

Decision rationale: In regards to the use of Naproxen 550mg quantity 60, the request is not medically necessary medically necessary based on the clinical documentation provided for review and the MTUS guidelines recommendations. The chronic use of prescription non-steroidal anti-inflammatory drugs (NSAIDs) is not recommended by the MTUS guidelines as there is limited evidence regarding their efficacy as compared to standard over-the-counter medications for pain such as Tylenol. Per MTUS guidelines, NSAIDs can be considered for the treatment of acute musculoskeletal pain secondary to injury or flare ups of chronic pain. There is no indication that the use of NSAIDs in this case was for recent exacerbations of the claimant's known chronic pain. As such, the patient could have reasonably transition to an over-the-counter medication for pain. Therefore, the request is not certified.