

Case Number:	CM14-0007565		
Date Assigned:	02/10/2014	Date of Injury:	02/17/2009
Decision Date:	06/09/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/21/2014

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 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 36 year old male injured on 02/17/09 due to an undisclosed mechanism of injury. Current diagnoses include lumbar radiculopathy, lumbar failed surgery syndrome, chronic pain, spinal cord stimulator malfunction, insomnia, and headaches. The clinical note dated 12/17/13 indicates the injured worker presented complaining of low back pain radiating to bilateral lower extremities rated at 8/10 without the use of medications. The injured worker reports activities of daily living limitations to include self-care, hygiene, activity, ambulation, and sleep. Physical assessment revealed slow gait assisted with the use of a cane, lumbar spine range of motion decreased, spinal vertebral tenderness in the lumbar spine at L4-S1, lumbar myofascial tenderness and paraspinous muscle spasm noted on palpation. Medications prescribed include Gabapentin 600mg QID, Senakot-S BID, Restone 3/100mg QHS, Ibuprofen 800mg Q 8 hours, Orphenadrine Citrate ER TID, Butalbital /Acetaminophen/caffeine 50/325/40mg Q 6 hours, Tramadol ER 150mg QD, and Pantoprazole 20mg QD. The request for authorization dated 02/06/14 indicates the patient had recently undergone successful trial of intrathecal Morphine with a plan to wean him from Morphine and other oral opioids once the intrathecal pump is authorized. The request for Butalbital/Acetaminophen/caffeine 50/325/40mg #120, Tramadol ER 150mg #30, Pantoprazole 20mg #30, and Orphenadrine Citrate ER #90 was initially non-certified on 01/03/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

BUTALBITAL/APAP/CAFFEINE 50/325/40MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesic Agents (BCAs), Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesic Agents (BCAs), Page(s): 23.

Decision rationale: As noted on Chronic Pain Medical Treatment Guidelines, Barbiturate-containing analgesic agents (BCAs) are not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. Additionally, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As such, the request for Butalbital/APAP/Caffeine 50/325/40mg #120 is not medically necessary.

TRAMADOL ER 150MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use, Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, therefore the request for Tramadol ER 150mg #30 is not medically necessary.

PANTOPRAZOLE 20MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk, Page(s): 68-69.

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: As noted in the Official Disability Guidelines - Online version, Pain Chapter, proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. Risk

factors for gastrointestinal events include age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no indication that the patient is at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. As such, the request for Pantoprazole 20mg #30 is not medically necessary.

ORPHENADRINE CITRATE ER #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 65.

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

Decision rationale: As noted on page 63 of the Chronic Pain Medical Treatment Guidelines, muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the patient has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the request for Orphenadrine Citrate ER #90 is not medically necessary.